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Resilience in counselling and clinical psychologists working in the NHS a grounded theory investigation

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Resilience in counselling and clinical psychologists working in the NHS: A grounded theory investigation

by

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Abstract

This study aimed to develop a constructivist grounded theory (CGT) of how counselling and clinical psychologists understand and sustain resilience in the context of their work within the National Health Service (NHS). Recent surveys have highlighted that NHS mental health practitioners report high levels of professional burnout and low levels of job satisfaction due to increasing demands, with workers required to meet ever higher targets. Resilience, conceptualised as the ability to sustain professional effectiveness, fostering psychological wellbeing, is suggested to be a protective factor against burnout. Despite its relevance, there is no research that explores the mechanisms of resilience in the NHS. Therefore, the current study recruited nine counselling and clinical psychologists who identified as resilient, and, as part of a negative case analysis, a cognitive-behavioural therapist and a clinical psychologist who didn't identify as resilient. Participants were interviewed about their experience of resilience in the NHS. The interview data were subjected to a grounded theory analysis. The theory developed proposes that values, and in particular the extent to which a practitioner's personal and professional values align with the values of their organisation, appear to play a central role in the way resilience is experienced and negotiated. The overarching aim of this study was to develop insights that may enhance the provision of support for the NHS psychology staff. Recommendations include suggesting that employers take a more active role in supporting psychology staff wellbeing, the need for more effective communication between practitioners and management, as well as potential implications for training. Suggestions for future research include exploring a male perspective and non-psychologists, using discursive approaches to investigate resilience within this context, as well as investigating further the possible link between alignment of values and resilience in the NHS.

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Chapter One

Introduction

1.1 Background

Supporting the wellbeing of mental health practitioners is becoming central in maintaining the workforce in the current NHS context, one characterised by high demands and limited resources (Rao, 2019; Jackson, 2019). It has been suggested that supporting the wellbeing of mental health practitioners needs to be a key priority given the emotive nature of therapy work, impact that therapy work can have on a practitioner's personal life and the relationship between practitioner wellbeing and client outcomes (Beutler, et.al., 2004; Picker Institute Europe, 2015).

A recent national UK survey conducted by the 'New Savoy Partnership (NSP)', a coalition of organisations with the scope to advocate for the wellbeing of mental health staff within the NHS, highlighted worrying trends in regard to levels of stress, professional burnout, depression and low morale in NHS mental health staff (Rao, 2019, British Psychological Society, BPS, 2017; The New Savoy Partnership, n.d.). Despite awareness of these issues and efforts to support staff wellbeing, results from a more recent survey suggest that levels of distress among the workforce have not diminished (Rao, 2019; BPS, 2018).

Psychological research also suggests that personal resilience can act as a significant protective factor against professional burnout (David, 2012). Despite this, in the United Kingdom (UK), resilience-related research on mental health practitioners largely focuses on risk factors, and no studies have been found that examine how NHS mental health practitioners understand and sustain resilience.

Consequently, the current study investigated how counselling and clinical psychologists understand and sustain resilience in the context of their work within the

NHS. It is the hope that this may facilitate insights to possibly develop a best practice approach in supporting practitioners' wellbeing in this specific social context.

1.2 Reflexivity Statement

Given the CGT methodology and my identity as counselling psychologist, I engaged in reflexivity throughout the investigation. This involved an evolving process of self-reflection to consider the impact that I, the researcher, had on each stage of the research (Kasket, 2015), starting by stating my interest and personal relationship with the chosen topic. I did not engage in reflexivity with the aim to minimise my impact upon the research but rather, to remain open to possible alternative interpretations of the data.

My interest in the concept of resilience stems from my personal experience and attitude towards difficult situations, developed through my experience as a young professional skier, in which an accident forced me into a career change. I struggled to recover from that, but eventually, I did 'bounce back' and I always thought of it as being a sign of resilience, a characteristic that I developed as part of that struggle.

While I was searching for the topic of my doctoral research, the term resilience struck me repeatedly, and I recalled how my life has been shaped by the experience of having 'bounced back', also wanting to help others find ways in which to cope and manage their challenges. While looking for my topic, I read an article about NHS mental health staff reporting high levels of distress, which immediately sparked my curiosity and saw a possible way of joining those two worlds, resilience and NHS research.

Furthermore, I recognise the need to make a bigger effort to support mental health practitioners; I believe that because of their professional role, they are often expected to be self-reliant and these expectations might make it harder for

practitioners to access support. Finally, having trained as a counselling psychologist, I appreciate that clinical and counselling psychologists differ in terms of ethos and training. This may have an impact in the way these practitioners sustain their resilience within this context.

Chapter 2

Literature Review

2.1 Introduction

This chapter aims to illustrate the most relevant literature in this research area to provide a context for the present investigation. The following review is the combined product of two literature searches: one conducted in April 2017 and another conducted in October 2019.

An overview of the status of research on resilience is provided, discussing existing literature of resilience and burnout, the factors that are shown to both impact and support practitioners' wellbeing, coping strategies and career-sustaining behaviours. Following this, an overview of literature regarding the current NHS environment is presented as well as the types of interventions available to support practitioners. The chapter concludes by outlining research closest to mine and state the rationale for the present study.

2.2 Conducting the Systematic Literature Review

2.2.1 Method

Four online databases (PsychInfo, PubMed, Science Direct and Medline) were searched using keywords and Boolean operators to identify relevant literature (Appendix A), using search terms related to variants of mental health staff, combined with terms related to resilience. The literature review conducted in October 2019 was divided into two searches. One search was used to update the literature from the previous search; while the other was used to integrate my findings within the existing literature (Charmaz 2014), and incorporated into the discussion chapter. Additional terminology was added in the second literature search, guided by concepts that emerged as significant from the grounded theory analysis, such as 'values' 'meaning'

'support' 'autonomy' 'appraisal of the situation' and 'relationship to self'. This search yielded hundreds of results and only the most relevant literature was included. Articles were screened by title and/or abstract in the initial stage; full texts of relevant articles were then reviewed. This produced 215 relevant results. The types of literature found by the search included journal articles, books, book chapters, systematic reviews, meta-analysis, qualitative and quantitative studies and unpublished dissertations. Articles were also identified through looking at reference lists of previous reviews and by directly contacting key authors in the field.

2.3 Overview of the Literature on Resilience-related Research in Therapeutic Practice

The practice of psychological therapy has been known to place particular emotional demands on the therapist (e.g. Sussman, 1995; Skovholt & Trotter-Mathison, 2013).[1] Studies have shown that therapeutic work-related stress can significantly impact therapist's wellbeing, and lead to the development of symptoms such as negative-self appraisal, anxiety and depression (Freudenberger & Robbins, 1979; Norcross, 1990; Neumann & Gamble, 1995; Grouch & Olsen, 1994).

Furthermore, a compelling and consistent narrative within the literature suggests that organizational context-related factors such as work demands, lack of resources and support, to name a few, can also have a detrimental impact on the practitioner's wellbeing (Hannigan, et al., 2004; Gilroy, et al., 2002; Pope & Tabachnick, 1994; Johnson & Hall, 1988; Maslach, et al., 2001).

In the literature, these occupational hazards, as well as contextual factors, are often investigated with regard to burnout (Maslach, 2003), compassion fatigue,

[1] The term 'therapist', 'mental health practitioner' and 'practitioner' are used interchangeably throughout the review.

secondary trauma (Figley, 1995) and vicarious trauma (McCann & Pearlman, 1990). These occupational hazards have been shown to negatively impact not only the physical and mental health of the practitioner, but also on professional outcomes and client care (Maslach et al, 2001; Hakanen & Schaufeli, 2012; Armon, et al., 2010; Bakker et al, 2014; Hall, et al.,2016).

Compassion fatigue, secondary trauma and vicarious trauma may be caused by continuous exposure to highly traumatised client groups (Figley, 1995; McCann& Pearlman, 1990). Burnout has a more general connotation, less closely linked to exposure to suffering or traumatised clients. It is defined by Maslach (1998) as a response to constant interpersonal and emotional stressors in the work environment, and as having three dimensions: emotional exhaustion, depersonalisation and a sense of reduced personal accomplishment.

Given the potential negative impact of these occupational hazards on the wellbeing of the therapist, and quality of care, it is unsurprising that the term 'resilience' has been researched in relation to mental health professions (e.g. Aburn, et al., 2015; Luthar, et al., 2000). A significant contribution to our understanding of therapist resilience in relation to these emotional risks comes from a correlational study conducted in the United States (US) by David (2012). This aimed to investigate the relationships between compassion fatigue, as measured by the Professional Quality of Life Scale fifth version (ProQOL-V; Stamm, 2009); and resilience levels, as measured by the Connor-Davidson Resilience Scale (CD-RISC; Connor & Davidson, 2003) in a range of healthcare professionals. Participants (N=275) included counsellors, social workers, psychotherapists, doctors, and nurses working with PTSD or trauma survivors. A positive correlation was found between resilience and compassion satisfaction ($B= 0.94$, $p<.001$) and a negative one between resilience and

burnout (B= -0.92, p=<.001). No relationship was found between individual factors such as years of clinical experience, caseload, gender, type of qualification, and level of resilience. Other studies indicate a lower risk of burnout amongst more experienced practitioners, suggesting higher levels of resilience (Craig & Sprang, 2010; Ackerly, et al., 1988).

Conducting and interpreting research on resilience can be challenging as it lacks a unified conceptualisation and the idea can be operationalised in different ways (Fletcher & Sarkar, 2013). Resilience has sometimes been conceptualised as a trait/characteristic (e.g. Connor & Davidson, 2003; Block & Block, 1980); as a personal resource (Hobfoll, 1989; Hobfoll, Johnson, et al, 2003); as a process (e.g. Masten, et al.,1990; Luthar et. al, 2000; Davydov, et al., 2010), and as an outcome (e.g. Smith-Osborne, 2007; King, et al., 2003). However, most definitions are based on the idea of positive adaptation to adverse situations (Fletcher & Sarkar, 2013; Bonanno, 2004; Leipold & Greve, 2009; Kaplan, 2005; Scoloveno, 2016).

Another challenge to research in this area is related to the conceptual fuzziness between related but distinct concepts, such as resilience and coping. These terms are often used interchangeably (Fletcher & Sarkar, 2013) despite evidence suggesting they are quite different (Campbell-Sills, et al., 2006; Major, et al., 1998; Van Viet, 2008). It has been suggested that 'resilience' influences the way a situation is appraised, while 'coping' refers to behaviours or strategies in which an individual engages following appraisal of a situation as distressing (Lazarus & Folkman, 1984).

It is also useful to distinguish between the concepts of resilience and wellbeing. These concepts are also related but conceptually different. Wellbeing is a broad concept concerning optimal functioning (Ryan & Deci, 2001), encompassing both psychological and physical states. However, for this review, only psychological

wellbeing will be explored. Further, the eudaimonic perspective on wellbeing will be used to for the purpose of this review. This perspective conceptualise wellbeing in relation to how the individual is functioning (Ryff, 1989). Thus, resilience could be considered to foster wellbeing, rather than being synonymous with it.

Furthermore, it could be said that resilience is often used as a 'synonym' of the absence of burnout, even though these are different constructs. It might therefore be important to differentiate between burnout and resilience research, even though both strands are concerned with practitioner wellbeing.

A variety of models of resilience have been developed over the years (Kumpfer & Hopkins, 1993; O'Leary, 1998; Bonanno, 2004). However, these models are not tailored to a specific working context and do not necessarily apply to mental health practitioners.

Winwood, Colon and McEwen (2013) conducted two cross-sectional studies aimed at developing a reliable scale to measure resilience at work. The first study included 355 participants (85 males), including health workers, manufacturing industry workers, teachers, IT, commerce and financial offices workers. The authors developed 45 statements which reflected behaviours, attitudes and mental states, considered to be the foundation of a resilience attitude. These statements were developed through a review of relevant literature. The study used an online questionnaire of 103 items that included the 45 resilience items and several validated measures as outcome variables (physical health, work engagement, chronic fatigue, recovery and sleep health). An exploratory factor analysis was then conducted. A resilience at work (RAW) scale of 20 items was developed as a result. The second study was carried out with a different sample of 195 participants (63 male) to analyse how the RAW scale score related to validated outcome measures. The online

questionnaire included the same scales used in the previous study with the addition of measures of work resources, demands and acute fatigue. A model of how the resilience scale total score developed in the previous study, interacted with the variables included in this study was created. The model supports the notion that resilience has an impact on the recovery of the individual from the stresses of work demands, which in turn seemed to be associated with better engagement, and had a positive effect on the individual's physical health. In this study, resilience has been conceptualised as a skill, associated with the engagement in behaviours that are consciously modifiable. However, this study does not investigate mental health practitioners.

Specific models of resilience in mental health practitioners have not been found. It, therefore, may be important to develop a theoretical understanding of this phenomenon.

2.4 Theoretical Models of Burnout

Several theoretical models of burnout have been proposed. The Job Demands-Control Model (Karasek, 1979) suggests that the person experiences burnout when there are high job demands, and low autonomy/control. Two subsequent models were then built on this one. One was named the job Demands-Control-Support Model (Johnson & Hall, 1988) which introduced a social support element. The second model developed, was the Job Demands-Resources Model (Demerouti, et al., 2001) which identified multiple resources (e.g. supervision) in reducing burnout. Finally, the Areas of Worklife Model (Leiter & Maslach, 2003) proposed six areas of workplace stressors, including: control, fairness, workload, community, reward and values. This model proposed that incongruence between the individual and the job across these domains contributes to burnout.

These models have been built on research investigating professionals from a wide range of educational and occupational backgrounds and given the empathic nature of therapeutic work, it is possible that mental health practitioner's resources are challenged in unique ways.

Some of these models have been applied to investigate predictors of burnout in mental health practitioners. A study conducted by Towey-Shift & Whittington (2019) in a NHS Community Mental Health Team investigated how person-job congruence was related to compassion satisfaction and compassion fatigue, and how these variables were associated to the practitioner's recovery attitude. The study found that workload, values and reward domains described by Leiter and Maslach (2003), were all negatively associated to burnout. However, workload was the only consistently significant predictor over compassion satisfaction and compassion fatigue.

Another study conducted by Merriman (2017) in a child and adolescent mental health service in the UK, investigated which domains of work life (Leiter & Maslach, 2003) were predictive of burnout and the role of self-efficacy. The findings suggest that only, workload and rewards were predictors of emotional exhaustion, and practitioner's self-efficacy was the stronger predictor of personal accomplishment.

A recent quantitative study conducted by Malik (2018) on the job Demands-Resource Model investigated the role of practitioner's personal resources in the relationship between work engagement and burnout. The findings suggested that job resources were the greatest predictors of work engagement, while job demands were the greatest predictors of burnout. Personal resources however, did not appear to significantly affect these relationships.

Taken together these studies seem to suggest that these models are good empirical instruments to investigate predictors of burnout. However, whether or not these studies also contribute to the understanding of the mechanisms behind the phenomenon of sustaining resilience is less clear.

2.5 Factors that Impact Negatively on Mental Health Practitioner Wellbeing

Sustaining caring relationships with emotionally challenging, traumatised clients, the practitioner's personal experience (e.g. childhood trauma) and client outcome seem to be factors that may negatively impact on practitioner's wellbeing (Stebnicki, 2007; Pearlman & MacIan, 1995; Ghahramanlou & Brodbeck, 2000; VanDeusen & Way, 2006; Way, et al., 2007; Nelson-Gardell & Harris, 2003).

Another factor found to impact therapists' resilience is their work context. For example, research suggests that practitioners working in organisational/public settings report higher levels of burnout and lower levels of job satisfaction compared to practitioners working in private practice (e.g. Ackerley, et al., 1988; Vredenburgh, et al., 1999; Dupree & Day, 1995; Lim, et al., 2010).

A systematic review of stressors and stress management in clinical psychologists working in the UK (Hanningan, et al., 2004) found that the most frequently reported stressors related to long working hours, experiences of poor management, excessive workload, lack of confidence, and client characteristics (e.g. recalcitrant clients). A qualitative study using interpretative phenomenological analysis (IPA) conducted by Charlemagne-Odle, Harmon, and Maltby (2014) that aimed to investigate the experience of distress in clinical psychologists (N=11) working in Britain, suggested that stressors were associated with excessive working hours and organisational expectations; further, this sample tended to delay or not engage in help-seeking behaviour due to fear of being seen as "a client". The

association of support-seeking with shame has been confirmed by studies among NHS staff (BPS, 2017; Brooks et al., 2014; Hillis, et al., 2012; Walsh & Cormack,1994).

2.6 Factors that Support Mental Health Practitioner Wellbeing

2.6.1 Individual Factors

Available research suggests that individual factors that can promote resilience among mental health practitioners include personality traits (Bakker, et al., 2006; Killian, 2008; Lent, & Schwartz, 2012; Somoray, et al., 2016), individual characteristics such as age, with younger therapists at greater risk of burnout (Ackerley et al., 1988; Gilibert & Daloz, 2008; Sodeke-Gregson, et al., 2013), self-efficacy (Baker, et al., 2007; Shoji, et al., 2015), emotional intelligence (Frajo-Apor, et al., 2016) and psychological flexibility (Vilardaga, et al., 2011).

In the US, some studies have focused on gaining a better understanding of the characteristics of expert, resilient therapists. Jennings and Skovholt (1999) conducted a qualitative study on master therapists, using a GT methodology. Peer nomination was selected as the method of recruitment for 10 master therapists (3=men, 7=women; all working in a private practice). Participants ranged in age from 50 to 72 years old, and years of clinical experience ranged from 21 to 41. The results of this study led to the development of the cognitive-emotional relational model of individual characteristics of master therapists. This included a cognitive domain: being eager to learn, valuing ambiguity and complexity; an emotional domain: being self-aware, open to feedback, emotionally mature, attend to their own emotional needs, engage in reflexivity; and a relational domain: have excellent relational skills and belief in the power of the therapeutic alliance.

Subsequently, another three qualitative studies utilised the same methodology of analysis and the same 10 participants from Jennings and Skovholt's study to

identified emotional wellbeing and resilience of master therapists, (Mullenbach's, 2000), how they build therapeutic relationships (Sullivan, 2001), and their application of ethical values to practice (Jennings, Sovereign et al. 2005). Skovholt, Jennings, and Mullenback (2004) combined the findings of these studies to build a picture of master therapists' characteristics. This resulted in the development of a set of 'Paradoxical Characteristics' of master therapists (Table 1), Identifying Characteristics (Table 2), Word Characteristics (Table 3), and Central Characteristics (Table 4).

Table 1

Paradoxical Characteristics of Master therapists (Skovholt, et al., 2004, p.131-141)

Drive to mastery	AND	Never a sense of having fully arrived
Able to deeply enter another's world	AND	Often prefer solitude
Can create a safe client environment	AND	Can create a challenging client environment
Highly skilled at harnessing the power of therapy	AND	Quite humble about self
Integration of the professional/personal self	AND	Clear boundaries between the professional/personal self
Voracious broad learner	AND	Focused, narrow student
Excellent at giving of self	AND	Great at nurturing self
Very open to feedback about self	AND	Not destabilised by feedback about self

Table 2

Identifying Characteristics of Master Therapists (Skovholt, et. al.,2004, p.131-141).

- High emotional health as evidenced by self-acceptance
- Understanding of the ambiguous complexity of human nature that precludes an enthusiastic acceptance of any one-dimensional view of human psychology
- Clear rejection of simplified theories and models for use with clients
- Focused motivation to develop self and the ability to be helpful to others
- In a maximum way, used their own life experiences as food for growth
- Deeply confident of the therapy process and their own therapy skills
- Non-defensive acceptance of their own limitations and flaws as evidenced by knowing they are not the best therapists for some clients
- Data from direct work with clients is highly valued
- Drawn to paradoxical, complicated, metaphorical, and profound descriptions of the human condition
- Feeling humility while keeping grandiosity and arrogance at bay
- A wide spirit of empathy from their own reflected and integrated life experiences
- Possession of an internal schema--a wisdom guide--consisting of thick webs of patterns, practices, and procedures developed over many, many hours of work
- A close congruence between personality and demands of the work environment, a "goodness of fit"
- Having the profound ability to respectfully enter the world of another and be of assistance there
- Living for years in a reflective, open style while searching for growth--personal and professional--has produced the Highly Functioning Self

Table 3

Word Characteristics of Master Therapists (Skovholt, et al., 2004, p.131-141).

Alive, Congruent, Committed, Determined, Intense, Open, Curious, Tolerant, Vital, Reflective, Self

Aware, Generous, Mature, Optimistic, Analytic, Fun, Discerning, Energetic, Robust, Inspiring, Passionate.

Table 4

Central Characteristics of Master Therapists (Skovholt, et al., 2004, p.131-141).

Domain 1. Cognitive Central Characteristics	Embraces Complex Ambiguity; Guided Now by Accumulated Wisdom; Insatiably Curious; Profound Understanding of the Human Condition; Voracious Learner.
Domain 2. Emotional Central Characteristics:	Deep Acceptance of Self; Genuinely Humble; High Self-Awareness; Intense Will to Grow; Passionately Enjoys Life; Quietly Strong; Vibrantly Alive.
Domain 3. Relationship Central Characteristics	Able to Intensively Engage Others; Acute Interpersonal Perception; Nuanced Ethical Compass; Piloted by Boundaries Generosity; Relational Acumen; Welcomed Openness to Life Feedback.

These studies have contributed to an understanding of the individual characteristics of master therapists, however they also have several limitations. The sample recruited was relatively small, all white and from the same geographical area, which might limit the applicability of the findings to other contexts. Furthermore, the validity of these studies may have been compromised by the multiple interviews conducted with each participant.

Even though experience and resilience are separate constructs, it could be suggested that studies on master therapist characteristics contribute to our understanding of the characteristics of resilient practitioners, given that a lower risk of burnout is generally observed in more experienced practitioners. This may suggest higher levels of resilience (Craig & Sprang, 2010; Ackerley, et al., 1988).

Only one study specifically explored resilient therapists' characteristics. Hou's (2015) qualitative study aimed to explore the characteristics of highly resilient

therapists, to gain a better understanding of how therapists overcome the challenges of their work and remain resilient.

Participants were recruited through two screening stages: peer nomination and two questionnaires, the CD-RISC (Connor & Davidson, 2003) and the ProQOL-V (Stamm, 2009). The final participant sample was composed of 10 participants (Table 5).

Table 5

Participants demographic characteristics (Hou, 2015)

Participants	sex/gender	Range of Age	Credentials	Race/ethnicity	Range of Experience (years)	Setting	Range of weekly client hours	Religion/Spirituality
1	Female	41-50	LP/PsyD	White	>20	University Counselling Center	11-20	None
2	Female	61-70	LP/PsyD	American Indian	>20	Private Practice and Community Clinic	31-40	Native American Spirituality
3	Male	51-60	LP/PsyD	White	>20	Private Practice	>40	None
4	Female	41-50	LMFT/MSE	White	16-20	Private Practice	21-30	Christianity
5	Female	61-70	LMFT/MS	White	>20	Private Practice	1-10	Buddhism
6	Female	51-60	LICSW/MSW	White	>20	Community Clinic	31-40	None
7	Female	61-70	LP/PsyD	White	>20	Private Practice	21-30	None
8	Female	41-50	LP/PsyD	White	11-15	Private Practice	11-20	Christianity
9	Female	41-50	LP/PsyD	White	11-15	Private Practice	11-20	None
10	Female	41-50	LP/PsyD	White	11-15	Community Clinic	31-40	None

A grounded theory (Strauss, & Corbin,1998) approach was used to analyse the data. The study found that resilient therapists have a framework of core beliefs and values - they work within a theoretical approach and have a personal understanding/view of distress - engage actively with the core self - they are self-aware and proactive in taking care of their needs - have a strong desire to grow and learn, and are drawn to strong interpersonal relationships (Hou, 2015).

This study contributed to our understanding of the characteristics of resilient therapists. However, the lack of cultural, ethnic, and gender diversity might limit insights. In addition, most participants worked with upper-middle or upper-class clients; thus, their experiences might not be relevant to therapists working with lower socio-economic status clients. Furthermore, peer nomination, in which other resilient therapists might not be included due to a lack of social or professional connections, could be problematic. Moreover, the majority of participants were working in a private practice setting and as previously suggested, a higher level of burnout is associated with different work settings. Finally, the study was conducted in the US and given the contextual differences in mental health provision between the two countries, the insights these findings afford into a UK NHS context might be limited.

2.6.2 Organisational Factors

The literature suggests a consistent relationship between burnout and control in the workplace (Rupert et al., 2015; Lee et al. 2011; Ruper & Morgan, 2005). It is not clear what aspect of control is more helpful, as in these studies control was often measured using a scale whose items represented different aspect of control, such as control over work activities, case management and treatment used (Rupert et al., 2015). Furthermore, it might be difficult to generalise the aspect of control that is more helpful, as it could be dependent on work setting and professional experience.

Another factor that has been shown to foster practitioner's resilience is the support provided by others (Rupert et al., 2015; Sodeke-Gregson, et al., 2013; Lamb & Cogan, 2016). Some studies investigated support in the workplace as a general construct, others have investigated support as coming from co-workers and/or supervisors (Rupert & Kent, 2007; Ben-Zur & Michael, 2007). When support was conceptualized as a general construct, it was found to be positively associated with a

sense of accomplishment (Rupert & Kent, 2007). Two studies have been found that differentiated between support received from co-workers and supervisors. These studies suggest that the support received from supervisors was positively associated with an increased sense of personal accomplishment and negatively associated with depersonalisation as well as emotional exhaustion (Ross, et al., 1989; Huebner, 1994). When the support was coming from co-workers instead, the results were less consistent. One study found a positive relationship between this dimension of support and sense of accomplishment (Huebner, 1994), while the other did not find a significant relationship between dimensions of burnout and this dimension of support (Ross et al., 1989).

Similarly to control, the relevance and impact of support might also be dependent on practitioners work setting and experience.

2.6.3 Coping Strategies, Self-Care, and Career-Sustaining Behaviours

A well-established literature exists on the role that self-care, career-sustaining behaviour, and coping strategies play in maintaining therapist resilience. Literature on coping strategies suggests that problem-focused strategies (e.g. active strategies) are associated with higher personal accomplishment and less depersonalization (Maslack, 2001; Ben-zur & Michael, 2007). Furthermore, a quantitative study of coping strategies and subjective wellbeing on a forensic mental health team in the UK (Cramer, et al., 2019) suggested that experiencing and expressing emotions was positively related to indicators of wellbeing as well as social support, whereas avoidance was associated with burnout.

Different coping strategies have been found among psychologists working across different settings (Oren, 2012). Psychologists working in private practice settings tend to engage in more active coping strategies (e.g. problem-focused) while

psychologists working in organisations/agencies tend to engage in more avoidant coping strategies (Carver, et al., 1989). Psychologists working in organisations may have little control over work demands, which could influence their choice of coping strategies. These findings emphasise the importance of considering the type of work setting when investigating practitioners' coping strategies.

Different frameworks/guides for psychologist's self-care have been developed (e.g. Norcross and Guy, 2007; Baker, 2003; Carroll, et al., 1999; Skovholt, Grier et al., 2001); the themes that emerged most consistently are related to the importance of taking care of themselves in both their professional and personal life, maintaining professional growth, creativity, and a good work-life balance.

Different terms have been associated with self-care, such as career-sustaining behaviours, (Stevanovic & Rupert, 2004; Kramen-Kahn & Hansen, 1998; Rupert & Kent, 2007) and well-functioning strategies (Coster & Schwebel, 1997). These behaviours/strategies include: physical exercise, good sleeping patterns, engaging in meditation and leisure activities (Schauben and Frazier, 1995), maintaining a good work-life balance (Coster & Schwebel, 1997; Mahoney, 1997), engaging in cognitive stress-relief strategies (Rupert & Kent, 2007), self-awareness (Coster & Schwebel, 1997; Goncher et al., 2013), sense of humour (Goncher et al., 2013; Kramen-Kahn & Hansen, 1998), and maintaining their professional identify (Coster & Schwebel, 1997; Rupert & Kent, 2007).

A systematic review of UK clinical psychologists indicated that the most utilised coping strategies were physical exercise and support-seeking (Hanningan et al., 2004). Personal therapy has been considered a self-care activity (Macran et. al., 1999; Norcross, 2005; Orlinsky, et al., 2005; Daw & Joseph, 2007).

Furthermore, different groups of psychologists are characterised by differences in professional training and value-based practice, which may represent differences in coping mechanisms/self-care activities and risk-factors. For example, while counselling psychologists are required to engage in personal therapy during training, clinical psychologists are not (Daw & Joseph, 2007).

Another distinction that may be worth making is between therapists/counsellors and psychologists (McCann et al., 2013). A quantitative study by Lawson (2007) on a sample of American counsellors and counselling/clinical psychologists (N=501) showed that the choice of coping strategies that psychologists found most helpful, such as engaging in personal therapy and supervision, were not the coping strategies most endorsed by counsellors. Furthermore, psychologists seemed to engage more in self-care activities associated with professional growth and taking regular vacations; whereas self-care activities endorsed by counsellors were related to engaging in leisure activities and maintaining self-awareness (Lawson & Mayer, 2011). These findings suggest that these professional groups might not be as similar as they appear. Of particular relevance for the UK context, it is important to consider that counsellors/therapists and psychologists often have different roles within the NHS (Kennedy & Arikut-trek, 2016; Fairfax, 2016).

2.7 The Current NHS Environment

In the UK, psychologists have reported increasingly higher levels of distress and lower levels of psychological wellbeing (Rao, et al., 2016; BPS, 2016). In the last two decades, the NHS has experienced significant challenges and transformations following the financial crisis of 2008, which seem may have contributed to an increase in workplace distress. Furthermore, the development of the Health and Social Care Act (Ham, et al., 2012) has created a more competitive, commercially driven

environment, as it has reinforced the marketization of the NHS (British Medical Association, 2017; The Kings' Found, n.d). It has been suggested that these changes have led to an increase in demand and a shortfall in resources, with employees required to work toward tighter targets (Felstead, et al., 2013; Sull, et al., 2015). More frequent sick leave has been found in mental health services compared with other services in the NHS (Quality watch, 2015).

It would appear that given the current economic situation, the stressors within the NHS as an organization exceed stressors directly associated with therapeutic work. Since 2014 the BPS and the NSP have been conducting annual surveys exploring the wellbeing of psychological professionals. Findings from this survey conducted in 2015 indicated that 46% of practitioners reported depression, 70% reported finding their job stressful, 49.5% reported feeling like a failure. These numbers are higher than those reported in 2014, with more than double the reported incidents of harassment and bullying and 12% more reports of stress at work (BPS, 2017). In 2016 the survey found 48% of practitioners reported depression –an increase of 8% since 2014 - (BPS, 2017). This trend has remained fairly consistent throughout the years. In 2017, fewer practitioners compared to previous years reported feelings of failure or depression, however, the practitioners who reported these feelings were still over 40% (43% feeling depressed and 42% feeling a failure; BPS, 2018) whereas incidents of harassment, bullying and feeling the weight of expectations to meet unrealistic targets continued to increase. Hence the latest findings still seem to provide cause for concern. Since 2014, the number of practitioners taking part in the survey, constantly increased (from 852, to reach 1678 in 2017; Rao, 2019), however, the latest survey saw fewer participants (1,037). In the survey conducted in 2018, the percentage of practitioners that reported feeling

depressed decreased to 40%, 82% reported finding their job stressful, which shows a decrease since 2017 in perceived flexibility and support (Rao, 2019). A further 23% of practitioners reported thinking about leaving the NHS and 78% - compared to 72% in 2017- felt that there was not enough staff to be able to deliver an effective and safe service (Rao, 2019). These are only some of the key highlights, but it paints a worrying picture where the level of distress and poor wellbeing do not seem to have shifted over the last five years. These trends are also confirmed by a recent survey conducted by the BPS (2019), clearly stating the pressure the psychology profession is under.

Despite awareness of the current situation, and the wide-ranging efforts of different professional bodies (e.g. BPS, NSP) for example, the implementation of joint initiatives, such as the development of a Charter for Wellbeing and Resilience (Hughes et al., 2016; Rao, Bhutani, et al., n.d); such efforts are not enough to make substantial changes to practitioners' wellbeing. Furthermore, considering that the findings from the different initiatives often lead to the development of different guidelines/recommendations, as well as having available NICE guidelines (NICE 2009) that provide recommendation on how to create a safe, inclusive working environment, we could say that we have enough theoretical resources/guidelines to address these problems. However, data from the latest survey reports alarming trends. More research is needed to investigate what might be going on, that is not being addressed.

2.8 Support Provided for Practitioners in the NHS

Available literature suggests that NHS trusts have different attitudes towards supporting practitioners' wellbeing, and not all trusts have in place a plan or policy to support practitioners (Sloan et al., 2014).

Current interventions for burnout can be described as being directed at the individual or at the organisational context (Johnson, et al., 2018). Interventions that focus on the individual are usually characterised as psychological interventions such as counselling, cognitive behavioural therapy (CBT) and mindfulness. Whereas interventions focused on the organisation, include changes to working schedule, educational interventions, staff support groups and training. It has been suggested that the most effective interventions are those that combine both organisational and individual interventions (Morse et al., 2012).

A recent systematic review and meta-analysis of studies that have investigated the effectiveness of interventions for addressing burnout in mental healthcare practitioners, conducted by Dreison and colleagues (2018), concluded that interventions were effective, however, the level of improvement was small (Hedges' g =.13, p = .006). Interventions included psychological therapy, stress-management workshops, staff training, and supervision. Specifically, the meta-analysis findings suggested that, when comparing interventions directed at the individual with interventions directed at the organisational setting, interventions directed at the individual were more effective. However, when the effectiveness of education and staff training interventions were evaluated on their own, it revealed greater improvements than interventions focused on the individual. These findings suggest that training and educational interventions may be a promising avenue to address burnout. The authors also highlighted the importance of designing interventions specifically tailored to the service.

2.9 Research on the Experience of Resilience in the NHS

In the time between my initial and the subsequent literature reviews, Wright (2017) conducted a mix-method study aimed to investigate the predictors of

depersonalization among NHS practitioners, and explored their experiences of burnout and resilience. Resilience was conceptualized within this study as a means to sustain practitioners' high standards of professional care. The sample (N=261) included social workers, mental health nurses, and clinical psychologists. No significant differences were found between professional roles in rates of depersonalization. The study suggests that the practitioners' specialty, years of experience, emotional exhaustion, personal accomplishments and exposure to physical abuse, were significant predictors of depersonalization. Thematic analysis was used to analyse participant responses to five open-ended questions in an online questionnaire. A deductive approach was used to develop the themes related to resilience or burnout. Themes identified as supporting resilience were: perceiving the value and meaning of their profession, good work-life balance and receiving support. Themes identified as hindering resilience were: limited promotion opportunities, little resources, low wages, and not able to give their best to clients.

Although this study contributes to the knowledge of what seems to support practitioners' wellbeing within the NHS context, it does not investigate how resilience is sustained by these practitioners, which might be significant in order to develop interventions to support practitioners working within this context. Furthermore, counselling psychologists were not included in the sample, and thus the findings cannot be generalized to the latter group.

2.10 Rationale for the Present Research

The lack of mental health practitioners' resilience-related research in the context of the NHS seems significant considering the struggle that the NHS workforce is facing. This provides a good rationale for conducting studies that

contribute to expand our understanding of the ways in which practitioners working within this context may feel they sustain their psychological wellbeing.

The literature reviewed provides a rationale for investigating counselling and clinical psychologists given their varied role within the NHS, and accounting for a large proportion of 'psychologists' working within this context (Kennedy & Arikut-trek, 2016; Fairfax, 2016). Further, different professional groups such as therapists and counsellors, appear to differ in terms of values-based practice and coping strategies. Thus, focusing on more compatible groups may allow for a clearer insight. These criteria might change following GT principles of theoretical sampling. Moreover, research on resilience in the UK has been conducted primarily with clinical psychologists. Greater insight into counselling psychologists experience of this phenomenon, and the possible differences between these two groups, would contribute to developing our knowledge.

Developing a theoretical understanding of this phenomenon, would have the potential to make a contribution to supporting the wellbeing of practitioners working in the NHS in these challenging times. Furthermore, given the contextual nature of resilience and the very particular challenges of the current socio-economic climate, it might be useful to investigate how resilience is understood within this context. Consequently, the present study proposes to investigate the following research question: "How do counselling and clinical psychologists understand and sustain personal resilience in the context of their work within the NHS?"

Chapter Three

Methodology

3.1 Introduction

This chapter will describe the choice of research paradigm, the researcher's ontological and epistemological stance, and the theoretical perspective and methodology underlying this research.

3.2 Choosing a Research Paradigm

A research paradigm provides a conceptual and philosophical framework that guides the researcher in defining the method and design of the study (Ponterotto, 2005), in line with their beliefs about the nature of reality (Mills, et al., 2006).

3.2.1. Qualitative vs Quantitative Paradigms

Qualitative research endeavours to understand and interpret how individuals experience and make sense of their world (Willig, 2013). Qualitative research aims to create rich data from a detailed description of a phenomenon provided by the participants within a specific context (Davidson & Tolich, 2003). The sample size of participants for qualitative projects is usually smaller than those for quantitative paradigms, and words are used as data (Clarke & Braun, 2013). Qualitative research often uses an inductive approach that seeks out emerging data patterns.

Conversely, a deductive approach is usually characteristic of a quantitative approach and involves gathering data to testing a specific hypothesis and identify relationships between particular variables (Richardson, 1996). The sample size is usually large, numbers are used as data and the findings may be generalised to a larger population (Clarke & Braun 2013).

Thus, given the aim of the study and the contextual nature of resilience (Aburn et al. 2015), qualitative methodology appears to be more suitable for this research

study. Further, qualitative methodology reflects my position and values as a counselling psychologist-in-training. Fundamental counselling psychology professional values are underpinned by humanistic principles. These include viewing the client as unique; prioritising the client's subjective experience; working towards the empowerment of the client, and the development of a non-hierarchical relationship (Orlans & Van Scoyoc, 2008). Similarly, qualitative research is designed to understand the individual's subjective meaning (Denzin & Lincoln, 2000), and thus valuing their subjective experiences. This could be seen as empowering the individual, being free to share their experience.

Moreover, Morrow (2007) suggested that qualitative research can be useful in exploring areas where there is little previous research. Given that no studies have been found examining how NHS practitioners understand and sustain resilience, qualitative methodology seems a pertinent choice for this study.

3.2.2. The Researcher's Ontological and Epistemological Stance

Using an inductive qualitative approach implicates the involvement of the researcher in the research process (Elliot, et al.,1999). Below, the researcher's ontological and epistemological stance will be outlined, since this impacts the type of knowledge the research aims to produce.

3.2.2.1 Ontological Stance. Ontology is concerned with the study of 'being' (Crotty, 1998), and addresses the question of what constitutes "reality" (Ponterotto, 2005). Ontological positions can be conceptualised along a continuum, where realism and relativism are situated at opposite extremes, and critical realism is located somewhere in the middle (Clarke & Braun, 2013). A realist ontological stance assumes the existence of a single, identifiable reality (Guba & Lincoln, 1994). This objective reality can be studied and measured, and exists independently of from

individual understanding. A relativist ontological stance instead, assumes the existence of multiple, constructed realities that are highly linked to the context in which they occur (Ponterotto, 2005; Scotland, 2012). Finally, a critical realist stance assumes the existence of a "true" reality but posits that our ability to measure this is always limited (Ponterotto, 2005).

Due to my interest in the prioritisation of subjective experience, and my personal views on what constitutes reality, I found it relatively easy to place myself within a relativist ontological position.

3.2.2.2 Epistemological Stance. Epistemology is concerned with what can be known about reality and how. It therefore involves consideration of the researcher-participant relationship in the process of knowledge creation (Ponterotto, 2005). Guba and Lincoln (1984) have suggested that there are three main epistemological stances, objectivism, subjectivism, and constructivism. I rejected objectivism reasonably confidently, as it assumes the existence of an objective truth (Crotty, 1998), that the researcher, the participant, and the phenomenon studied are mutually independent, and that by following rigorous procedures, the researcher can study specific phenomenon without bias (Ponterotto, 2005). This contrasts with my ontological positioning.

Subjectivism rejects the notion of an objective truth (Ponterotto, 2005), however, it accepts that the meaning is not constructed between researcher and participant, but resides within the participant (Clarke & Braun, 2013), which does not fit with my personal beliefs. Meanwhile, a constructivist approach supports the notion that reality is co-constructed in the interaction between the participant and researcher, disregarding the notion of an objective truth (Ponterotto, 2005). This is in line with

my ontological stance, positioning myself within a constructivist epistemological position.

3.3 Theoretical Perspective

A theoretical perspective is an abstract framework that provides a premise for viewing social contexts (Patel, 2015). Social constructionism forms this study's theoretical perspective. Social constructionism presumes the existence of multiple, subjective reality interpretations that emerge from people interacting with each other, whilst situated within a specific historical, sociocultural context (Charmaz, 2014, Schwandt, 2000). Thus, this research endeavours to raise an interpretation of how the investigated phenomenon is understood by the participants, accounting for the particular context wherein it is built. The inevitable impact of the researcher's subjectivity is acknowledged. Consequently, this research does not make claims or aim for universality or generalisability of the findings (Charmaz, 2014).

3.3.1. Symbolic interactionism

Symbolic interactionism holds the belief that meaning is constantly generated, maintained, and changed through social interactions; it is thus compatible with a social constructionism viewpoint (Blumer, 1969). Symbolic interactionism conceptualises people acting towards 'things', responding to the meanings that those 'things' personally hold (Charmaz, 2014). Such meanings arise, from past and present social interactions that are mainly interpreted and constructed through language (Blumer, 1969). This theoretical perspective was chosen given its emphasis on the subjective meaning-making process, and is thus in line with the researcher's philosophical stance and research question.

3.4 Chosen Methodology: Grounded Theory

The term "methodology" refers to an approach used to acquire knowledge of a particular phenomenon. It is related to a specific research paradigm, involving the use of certain methods to collect and analyse participants' data (Patel, 2015). Grounded Theory (GT) was selected as it aims to develop a theory depicting how groups of people experiencing the same context understand a particular phenomenon taking place within it (Charmaz, 2006). Hence, it chimes with the primary objective of the present study.

3.4.1 History of Grounded Theory

The classical version of GT (Glaser & Strauss, 1967) first evolved as an alternative to the predominant deductive research paradigm within sociology. Glasser and Strauss developed this approach with the objective of building up different understandings of social phenomena by producing theory which was inductively generated from the data (Glasser & Strauss, 1967). At the time, qualitative research was viewed as having little scientific validity as not underpinned by positivist epistemology (Charmaz, 2006).

The introduction of GT as systematic qualitative methodology challenged these beliefs, demonstrating that qualitative research could be seen as possessing scientific value, arguing that systematic data analysis would provide more containment and control over the research process, therefore increasing the analytical power of the researcher's work. Although Strauss later collaborated with Corbin (Strauss & Corbin, 1998) and developed a newer technical procedure in GT, this version still retains its positivistic stance (Charmaz, 2006). Newer versions moved towards constructionism and interpretivist paradigms. Although embedded within varied epistemological and ontological stances, these versions all share the aim of

developing an explanatory framework that is grounded in the data (Ramalho, et al., 2015).

3.4.2 Constructivist Grounded Theory

Charmaz (1990) developed the constructivist version of GT resulting from her dissatisfaction with the ontological and epistemological assumptions of the previous models. Indeed, Charmaz (2014) criticised the notion that the theory "emerges" from the data. She argued that this assumption does not consider the researcher's part in co-constructing the theory, nor does it treat the analysis as an accurate representation of the world, rather than a construction of it. Further, the researcher's subjectivity was viewed as requiring minimisation to avoid contamination of findings (Glasser & Strauss, 1967). Contrastingly, Charmaz (1990), argued that the researcher's subjectivity was not a "contaminating" factor. She questioned the notion that it is possible for the researcher to separate their subjectivity from the research process and contending that the researcher's personal interests and pre-existing concepts will always steer the direction of their research. This constructivist approach to GT values the researcher's subjectivity and encourages them to engage in reflexivity. It also highlights the importance of making this explicit to inform the reader of the assumptions and perspectives that the researcher is bringing to the process.

3.5 Rationale for Using Constructivist Grounded Theory

CGT was chosen, firstly, because it aligned with the ontological, epistemological and theoretical underpinning of the study. Secondly, similarly to counselling psychology, CGT supports social justice research, centred on the promotion of equality and fairness (Charmaz, 2011). Thus it not only aims to contribute to knowledge, but to provide insights to inform policy. In relation to the

current study, this may reflect the voice of mental health practitioners that may have been minimised given their professional title.

3.6 Alternative Methodologies

Given this study's objective to explore psychologists' subjective experiences, IPA (Smith, et al., 1999) was initially considered. However, IPA's theoretical underpinning derives from Husserl's (1931) phenomenological method that assumed that the researcher is able to bracket or suspend their assumptions. This did not align well with my personal ontological and epistemological stance. Further, IPA was disregarded as it does not consider as fully the role of the context, tending to give greater emphasis to individual psychological and subjective interpretation of the data (Smith et al., 1999).

Chapter Four

Method

4.1 Introduction

In this chapter, the processes, tools and techniques used for the collection and analysis of data (Robson, 2011) will be detailed.

4.2 Research Design

This is a CGT study drawing on semi-structured interviews, placed in a constructivist epistemology. Semi-structure interviews are often used with CGT (Robson, 2011). Their intersubjective nature fits well with CGT's notion of reality as socially constructed. Further, they allow flexibility to the interview providing a minimal structure by which to obtain relevant data, without narrowing participants' responses (Charmaz, 2014).

As I detail below (4.7), I conducted two rounds of data collection. I created an interview schedule (Appendix B) for the first round of data collection (P1-P9), and a slightly different version of this schedule (Appendix C) for the second round (P10-P11) guided by what emerged from the data (Charmaz, 2014).

4.3 Written Materials

The materials used in this study included a demographic Questionnaire (Appendix D); the Consent Form (Appendix E), the Study Information Sheet (SIS; Appendix F) and the interview schedule. The initial interview schedule (Appendix B) was developed using the research question as an anchor and reminder of the key focus of the study (Charmaz, 2014). I acknowledged that to answer the present research question, I needed data about participants conceptualisation of resilience, their experience of their work and how they cope with challenges. I also considered important to ask participants for examples of resilience work-related situations - or

lack thereof - to facilitate understanding of their subjective meanings. Further, I included questions that promoted a 'general' reflection about the topic, such as why they agreed to participate in the study, their experience of the interview and whether they had additional things to add. This was thought to further invite/promote unanticipated experiences to emerge (Charmaz, 2006).

4.4 Participants

Eleven participants were recruited across different NHS services in London, aged 30-54 (M=42.36). All participants identified as "female". Nine participants identified their ethnicities as "White"; six out of these nine participants further identified as "British"; one as "White European"; one as "White Other", and one as "White African". One participant identified as "Asian" and another as "Greek". Seven participants were clinical psychologists, three counselling psychologists, and one was a cognitive-behavioural therapist. Participants possessed between 3 and 16 years of NHS work experience. Seven participants indicated "CBT" as their theoretical orientation, and two indicated "third wave CBT". Moreover, the following theoretical orientations were indicated by one: "dialectical behaviour therapy" (DBT); "systemic therapy"; "schema therapy"; "compassion focus therapy" (CFT); "acceptance and commitment therapy" (ACT); eye movement desensitization and reprocessing" (EMDR), and Psychodynamic Theory (Table 6).

Table 6

Participants' Demographics

Participant	Gender	Theoretical orientation	Professional title	Years of practice since qualified	Years of practice in the NHS	NHS type of Service in which currently working
1	Female	CBT/third wave CBT/EMDR	Clinical psychologist	9	9	Secondary care Community adult mental health (CMHRS)
2	Female	CBT	Clinical psychologist	14	14	Working age adult community mental health recovery service
3	Female	CBT/third wave CBT	Clinical psychologist	3	3	Recovery & support team (CMHT)
4	Female	Integrative	Counselling Psychologist	9	6	CAMHS
5	Female	CBT	Clinical psychologist	20	15	Addictions (Gambling)
6	Female	Psychodynamic	Counselling Psychologist	4	4	Addictions
7	Female	Integrative/DBT/ CFT/Schema	Clinical psychologist	7	6.5	Personality disorder service
8	Female	CBT/ACT	Counselling Psychologist	12	9.5	Chronic pain service
9	Female	CBT/Systemic	Clinical psychologist	16	16	CAMHS
10	Female	CBT	CBT therapist	9	9	IAPT
11	Female	Integrative	Clinical psychologist	12	7	National Problem Gambling Clinic

4.5 Inclusion criteria

I established relatively broad initial inclusion criteria (Appendix G) for the first round of data generation to allow exploration (Morse, 2007). I included individuals who were counselling or clinical psychologists employed in any type of NHS service for at least three years post-qualification; were currently working in the NHS, and who identified themselves as "resilient". To assist self-identification as 'resilient', a brief definition was included in a SIS for potential participants. For the second round of interviews, the inclusion criteria (Appendix H) were expanded to

take account of what surfaced in the initial analysis, in accordance with the principles of theoretical sampling used in GT as explained in section 4.7.

4.6 Recruitment

A range of recruitment methods were employed. The study was advertised in the BPS Counselling Psychology Division e-newsletter (Appendix I), and in the Division of Counselling and Clinical Psychology Facebook Groups (Appendix J). Further, an e-mail (Appendix K) with attached the SIS was distributed to counselling and clinical psychologists based in London, whose e-mail addresses were obtained from the BPS Directory of Chartered Psychologists, explaining the nature of the study and asking if they wished to participate. Following these unsuccessful attempts, participants were recruited using the researcher's professional network, in particular, I asked my Director of Study (DoS) to send an e-mail with attached the SIS to their professional network; further participants were then recruited through my Co-Supervisor's professional network. Other trainees were requested to forward the SIS to practitioners who could potentially meet the inclusion criteria. Still, more participants were recruited through snowballing from interviewees' contact networks. Response rates differ across methods (Table 7).

Table 7

Overview of recruitment methods and response rates.

Recruitment method	No. contacted	No. agreed to take part	No. expressed interested but didn't consent due to time constrain	No. expressed interest but didn't meet inclusion criteria
Advertisement on BPS e-newsletter	Received by all DCoP members who subscribed to the newsletter.	0	0	1
Advertisement on DCoP and DCP Facebook groups	All members	0	0	0
E-mail to members of BPS 'Directory of Chartered Psychologists'	26	0	2	0
E-mail to DoS Professional network	50	5	0	1
E-mail to contacts from co-supervisor professional network	2	2	0	0
E-mail to contacts from other trainees' professional network	3	2	0	0
Snowballing from interviewees' contact networks	I have been contacted from them	2	0	0

4.7 Sampling

4.7.1 Sampling Procedure

Following GT principles, I used a non-probability sampling strategy for the first recruitment round. At the outset, the participant sample in round one contained a helpful level of diversity in terms of participants' experiences, enabling the creation of an initial overview of the phenomenon (Appendix L). This initial overview facilitated pattern identification across participants' experiences. I stopped round one of recruitment at the point at which I considered that the participants' interviews did

not reveal any new patterns. Here, all the concepts identified were stable for at least the last two interviews.

In the second round of interviews I adopted theoretical sampling. It allows testing or expanding an emergent theory by collecting data from participants who possess specific characteristics to maximise differences in terms of exploring a range of diverse experiences, and also minimises differences within the existing data (Glaser & Strauss, 1967). Employing this sampling technique enabled me to refine the relevance, properties, and boundaries of my existent categories (Charmaz, 2006).

I initially intended to recruit ten to fifteen participants; however, the sample size in GT research is determined by reaching the 'theoretical saturation' of categories. This occurs when the emergent theory could account for the all range of experiences described by the participants and when collecting further data does not lead to the development of new categories (Charmaz, 2014).

However, Charmaz (2014) has suggested reaching this point is difficult to achieve, as variations and new dimensions in the data can always be discovered. This notion is especially true of CGT, contending that different contexts, participants and/or researchers will always generate new interpretations of the data (Charmaz, 2014). In the light of this, I made the decision to stop recruiting participants when I reached 'theoretical sufficiency' of my categories. This was the point where I attained a sufficient degree of conceptual understanding of the properties of my existing categories and their relationships, perceiving these as sufficiently saturated (Dey, 1999). The concepts identified during the first round of interviews showed similar sets of patterns across participants, providing a deeper conceptual understanding of the phenomenon of resilience from participants who were either counselling or clinical psychologists and who self-identified as resilient. Once I had constructed an initial

GT from the first round of interviews, I identified a number of gaps and leads in the theory that seemed useful to explore further to increase the explanatory scope of the emerging theory. Therefore, for the second round of interviews, I recruited participants who possessed specific experiences and characteristics (appendix H) to address the gaps and leads identified. For instance, I decided to recruit professionals from other professional groups (e.g. therapists) to understand the specificity of my theory; as well as interviewing practitioners who did not identify as resilient and identified as male. This, contributed to define the boundaries of my preliminary theory.

Further, theoretical sufficiency was also achieved and assessed through using a constant comparative method (Charmaz, 2006). This involves making comparisons between emerging characteristics of the data and codes, and against the abstract concepts being developed, to check for possible new dimensions and properties. The codes developed in round two of data analysis contributed to unify, and better delineate, the boundaries and properties of my existing categories, whilst avoiding adding completely new concepts to the preliminary theory. Thus, theoretical sufficiency was deemed to be achieved at this point after 11 interviews (Appendix M).

4.8 Study procedure

Practitioners expressing interest in participating in the study and meeting the inclusion criteria were e-mailed (Appendix N). The SIS, the consent form, and the demographic questionnaire were attached. Practitioners were also requested to indicate a suitable date/time, and preferred location for the interview.

On the interview day, participants signed the consent form and completed the demographic form. The interview length varied between 34 and 80 minutes. Before

and after each interview I encouraged and responded to any question or concern participants had about the purpose of the study, its design or their participation, and I reminded them of their right to withdraw.

4.9 Analytic Procedure

Conceptualising data analysis as the process of constructing meaning from participants' data through the identification of patterns (Miles & Huberman, 1994), I utilised constant comparison of data (Glaser & Strauss, 1967). To compare different sets of data, I made the data more manageable via coding. Small data segments were labelled to denote their potential significance in the light of the research question (Urquhart, 2013). In keeping with the social constructionism perspective, it is acknowledged that this coding was influenced by my own subjective construction and interpretation. Employing GT guidelines, I coded my data using 'gerunds' rather than 'themes', considering the data in terms of actions and processes. This facilitated comparisons and connections between my emerging concepts to evidence the 'implicit' processes indirectly addressed by participants (Charmaz, 2014). Further, instead of using line-by-line coding suggested by Charmaz (2014), I decided to code "unit of meaning"; hence, assigning a code to a concept or a full action/idea (Morehouse, 2012), to avoid producing a large number of irrelevant codes (Stern, 2007).

The interviews were audio-recorded, and subsequently transcribed. Guidelines for transcribing interviews in GT are not prescriptive (Oliver, et al., 2005). However, data transcription in GT research generally excludes paralinguistic features (e.g. facial expressions; Oliver et al. 2005). Although Charmaz's approach to transcription exclude these, repetitions, pauses, and other fillers are included (O'Connel & Kowal, 1995). However, I decided to transcribe the interviews omitting paralinguistic

features, false starts and other fillers, perceiving these as comparatively less relevant to the aims of the analysis (Glaser, 1998).

4.9.1 Initial Coding

Initial coding entails staying close to the data and is designed to make sense of the data and define events occurring within it. The thinking process I used to assign the different codes at this stage was asking myself what the data was suggesting and constantly related this to my research question. I developed a personalised manual coding system, using alternate colours to delineate the beginning and end of each code (Appendix O).

4.9.2. Memo Writing

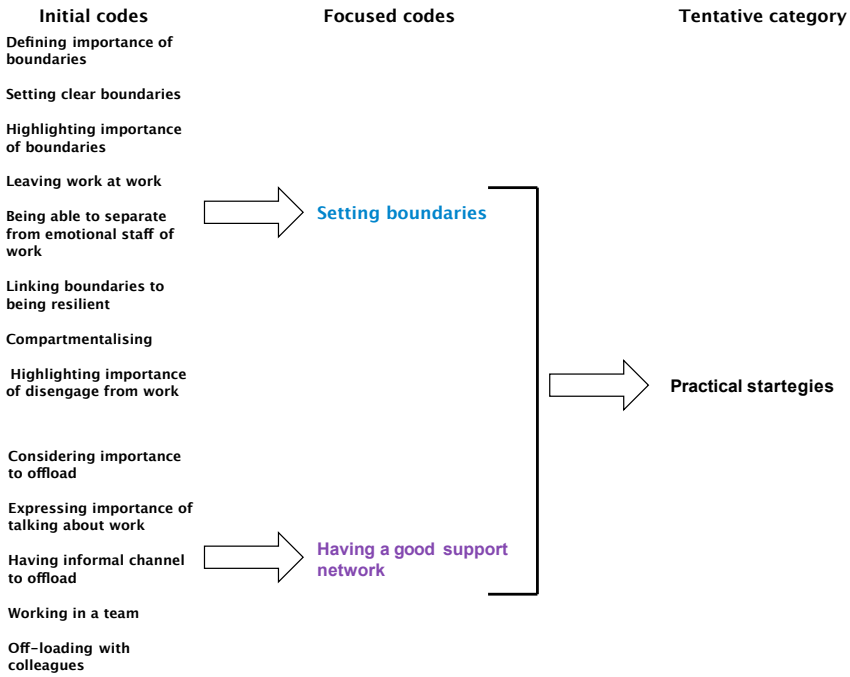
Following CGT principles, I wrote memos – informal, analytic notes (Charmaz, 2014) – throughout the investigation. The way in which memos were used varied at different stages of the analysis. At the data collection stage, I wrote a memo following each interview, noting my initial impressions and understanding of the main concepts and processes described by participants and/or any contrasts or patterns identified in relation to previous interviews (Appendix P). Hence, I detailed aspects of the process, and the content, and linked these to my research question. This enhanced my analytical thinking and the depth and abstraction of my analysis (Charmaz, 2006). At the analysis stage, I used memos to track and identify potential similarities in processes and patterns described by different participants, and to remain open to alternative interpretations (Appendix Q). During the analysis, I also wrote memos for each participant for each concept/category I developed, to define its properties and boundaries (Appendix R).

4.9.3. Focused Coding

The focused coding stage followed the initial coding procedure. Again, I developed a personalised manual system for creating focused codes using different colours (Appendix S). The focused coding stage in a GT analysis is more conceptual than initial coding, and involves identification of the initial codes that appear to be most significant and recurring. These are then complied into a tentative 'category' (Appendix R). This process helps to synthesise larger data segments and provide a provisional explanation of the experiences being described by participants (Charmaz, 2006). I considered each interview as a unique set of data and thus, I developed focused codes for each participant's interview. Then, I compared and contrasted against all other interviews and developed focused codes (tentative categories), across participants (Appendix T). An example of the passage from initial codes to tentative category is illustrated in Figure 1.

Figure 1

From Initial Codes to Tentative Categories

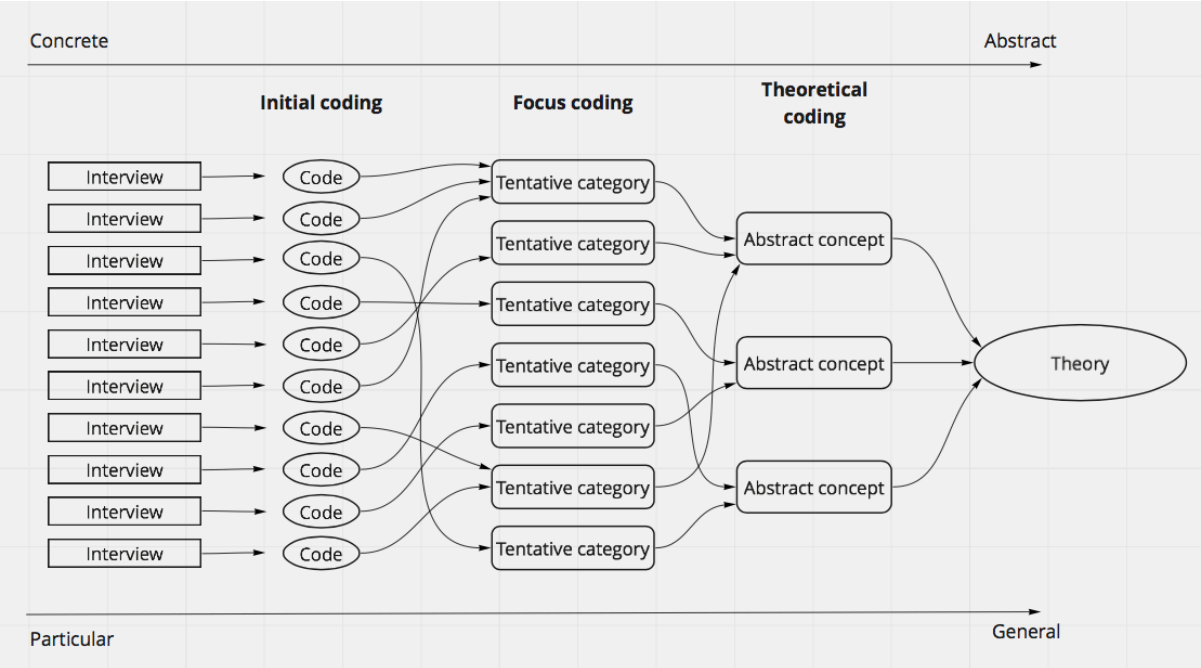


4.9.4. Theoretical coding

The final step in the analytic process is theoretical coding. I developed flashcards for data relating to each category (Appendix U), making easier for me to physically group together, separate, raise or subsume these. Theoretical coding involved constructing more abstract, higher order 'concepts' that subsumed a number of focused codes (Appendix V). This culminated in the development of a complete preliminary GT (Appendix W). The constant comparative method of data, alongside consultation with my supervisory team, allowed me to refine my tentative categories (Appendix X) and subsequently evolved into my final complete GT (Charmaz, 2014). An overview of the full coding procedure is illustrated in Figure 2.

Figure 2

Representation of the Complete Coding Procedure



4.10 Ethical Considerations

This research project was approved by the University of Roehampton Ethics Committee and conducted according to the BPS's Code of Human Research Ethics

(BPS, 2014). The main ethical issues raised by the proposed research are outlined below.

4.10.1 Informed Consent and Right to Withdraw

Participants received the study written materials before meeting with the researcher, providing participants with the opportunity to familiarise with these. These documents explained the voluntary nature of their involvement; the purpose of the research; what participation involved; the inclusion criteria, the study's approach to confidentiality, data storage and anonymity, and their right to withdraw at any point. Participants' signed a consent form prior to the interview.

4.10.2 Harm

Given the relatively non-sensitive nature of the topic and professional identity of the participant group, the risk of causing distress to participants in the interview was considered minimal. However, as resilience is closely related to experiencing challenging situations, it was considered possible that participants might disclose difficult or distressing experiences. In light of this, these 'risks' were made clear to participants before they decided to participate to enable informed consent. Further, participants were given a debriefing form (Appendix Y) upon conclusion of the interview, with contact details for the Employee Assistance Programme and the Occupational Health Department, from whom they could seek support if needed. None of the participants reported feeling distressed.

4.10.3 Data Protection

All data was collected and stored in accordance with the Data Protection Act (1998) and with the University of Roehampton Centre for Research in Social and Psychological Transformation's (CREST) Data Protection Policy (Appendix Z). Physical personal data and anonymised physical data were kept separate in a secure

locked location; electronic personal data and anonymised electronic data were kept separate and stored in a password-protected computer in an encrypted folder. All personal data including signed consent forms, participants' demographic details, and audio recordings were stored separately from the anonymised verbatim interview transcriptions, which were anonymised by removing all identifying details.

Chapter Five

Analysis

5.1 Introduction

This chapter provides a theoretical framework to understand how counselling and clinical psychologists understand and sustain personal resilience in the context of their work within the NHS. The framework was developed using a CGT approach (Charmaz, 2014).

This chapter is separated into two parts. The first part illustrates the diagram of my GT, a visual, schematic account of the interaction of all the categories developed. The second part includes the analysis of the findings of each category, its sub-category(ies) and the core category.

5.2 Preliminary Notes

The theory I developed results from my subjective interpretation of the participants' construction of the resilience phenomenon within the NHS within a specific point in time (Bryant, 2002). Being a consequence of my creation, the theory I propose is one of the many different possible interpretations of this set of data (Charmaz, 2014).

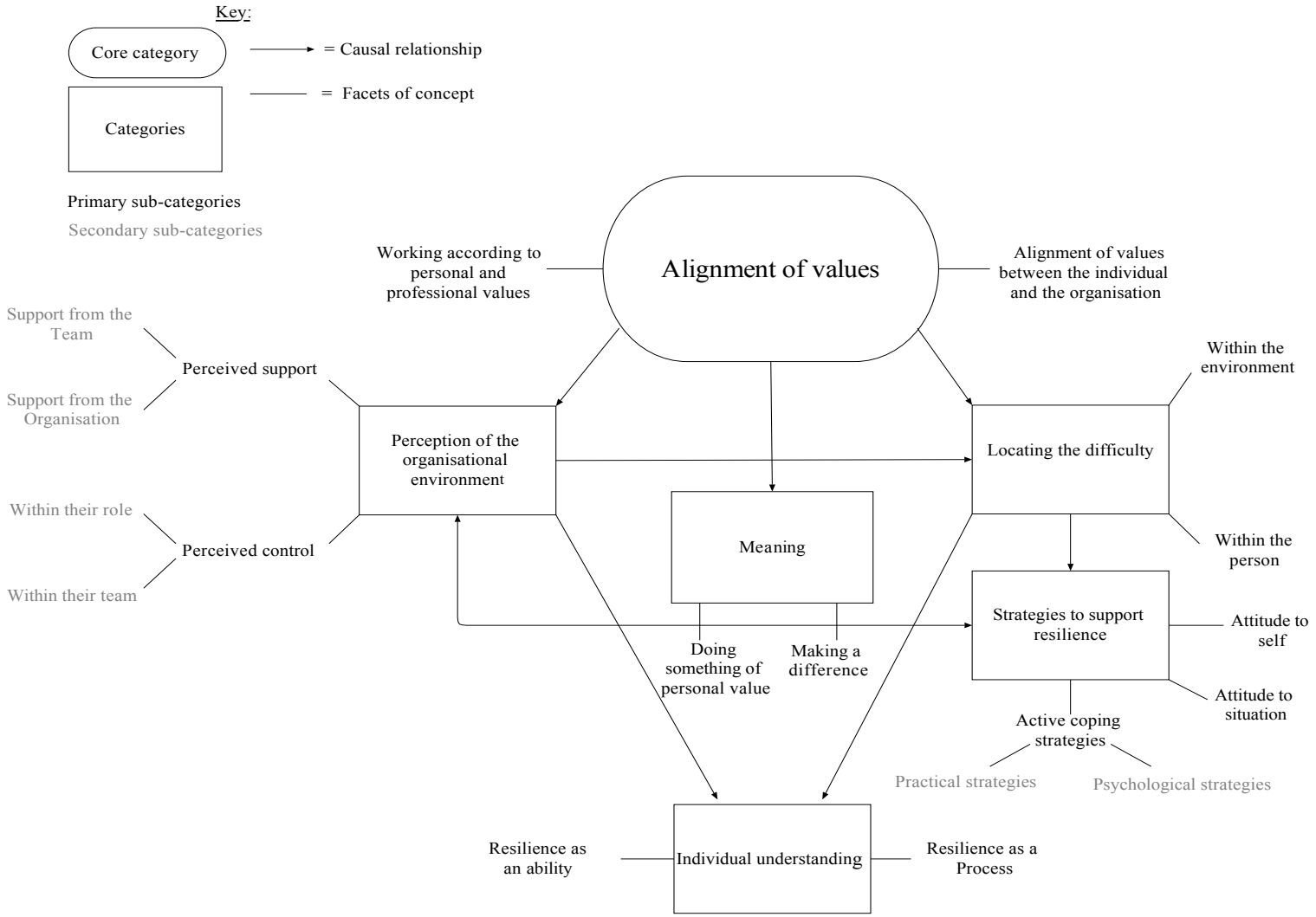
Further, I omit phrases like "I constructed practitioners as constructing x as…", which would offer a constructionist style of phenomenon description, emphasising the element of construction of meanings. Rather, I use a more direct, although still tentative language.

5.3 Part 1: Diagram of my GT

In this section, I provide a visual account of my GT including all the categories and their causal relationships I constructed from the data (Figure 3). This is followed by a narrative explanation.

Figure 3

Diagram of my Grounded Theory



As shown in Figure 3, the analysis indicated some differences in how practitioners seemed to understand resilience. For example, some participants conceptualised it as residing within the person, as if was an ability, while others viewed it as contingent upon interaction with an external environment, thus characterising it more like a process.

Interestingly, there seems to be a complex interaction between the different facets of data, and participant's individual understanding of resilience - whether they conceptualise resilience as an ability or as a process - seemed to be shaped by their perception of the organisational environment. Participants who described resilience as an ability of the person, talked about the organisational environment as being supportive. Additionally, they reported having a certain degree of control and autonomy over their work. Whereas participants who described resilience as a process seemed to perceive the environment as unsupportive and reported feeling a lack of autonomy within their work.

Participants' perception of the organisational environment would seem to determine where they locate the difficulty in sustaining resilience, as well as the type of strategies they used to cope with the challenges they experienced. Participants who perceived the environment as supportive and perceived a certain degree of control within their work, seemed to locate the issue in sustaining resilience within the individual. In contrast, participants who described the environment as unsupportive and reported having little autonomy, seemed to view the challenges practitioners face in sustaining resilience as a problem within the organisational environment.

Furthermore, it would appear that depending on where participants located the difficulty to sustain their resilience – whether as resulting from a problem regarding

the individual or the social context – it influences the type of strategies they used. In turn, engaging in these strategies seemed to contribute towards shaping the practitioner's perception of the organisational environment as increasing perceived support and control.

In the later stages of the analysis, it became apparent that the construct of values, mainly whether the practitioner's values appeared to align with the values of the organisation, was the currency in which the relationships between the different components described above were negotiated and defined. In fact, when participants described working in a way that felt to be congruent with their personal and professional values, and this was also congruent with the values of the organisation, participants seemed to perceive the organisational environment as supportive, having autonomy within their work and located the issue to sustaining resilience as resulting from a problem regarding the individual – for example, lacking the right set of skills to face the challenges of this context. Conversely, when these values did not align, participants struggled to sustain their resilience and tended to describe the organisational environment as unsupportive, placing the issue of sustaining resilience as resulting from a problem within the organisation.

Finally, the extent to which these values aligned, seemed to influence the level of perceived meaning participants experienced as a result of their work.

5.4 Part 2: Analysis of the Findings

In this section, I detail an exploratory analysis describing and defining each category constructed from the data.

5.4.1 Category: Individual understanding

This category denotes how participants constructed their understanding of resilience. Some participants appeared to describe resilience as an ability or a skill,

something that the person was *able to do*, while others talked about resilience as a process that involves some interaction with the environment. This category consists of two secondary sub-categories: *Resilience as an Ability* and *Resilience as a Process*.

5.4.1.1 Primary Sub-Category: Resilience as an Ability. Several participants considered resilience as an ability that a person may or may not possess. For example, P3 said:

> If someone hasn't got good emotion management strategies, they tend to be less resilient. So yes, I've got someone in the team at the moment who is, unfortunately, sadly, going to be leaving the team and I think a lot of that comes down to not having those good emotion management skills and getting very triggered, emotionally. (738-750)

It would seem that for this participant, what appeared to be determining whether someone stayed or left this working environment was not how aversive the context or work might have been, but how resilient the person was, and how effectively they could regulate their emotions. Therefore, P3 appears to emphasise that the responsibility for sustaining resilience rests with the individual. Similarly, P9 described resilience as a personal ability, and stated:

> I see myself as resilient practitioner partly because I don't manifest stress in physical ways, so I'm almost never ill at work. I literally don't think I've had a sick day in 10 years. So, stress doesn't seem to come out in a physical way. So therefore, I feel like I must have some ability to be able to manage it. (42-48)

It would appear that P9 considers resilience as something that helps fight the impact of work stress on her physical health.

Other participants seemed to link their conceptualisation of resilience to their professional identity as psychologists; for example, P1 said:

> You think how do I keep going, that's a hard thing to do but actually, you know, part of my identity is around being someone who works hard, who manages, you know, being successful, it's just kind of what we do. (298-302)

P1 here appears conceived of her professional identity as including an ability to be resilient, and hence it would seem she perceived herself as someone capable of managing with challenges, as did some other participants.

From these accounts, we could think of resilience as an ability that psychologists have, or should have. However, other participants who seemed to be struggling more with their working context, seemed to view resilience more as a process. This is explored in-depth in the next sub-category.

5.4.1.2 Primary sub-category: Resilience as a Process. As noted above, several participants seemed to conceptualise resilience as a process. I used the word 'process' to convey the idea that resilience was understood by some participants as the result of a sequence of actions/steps. For example, P8 commented:

> I think, as a resilient practitioner, it's finding a way to ride that wave in the most effective way whilst you can still feel proud of the work that you do and I think that's usually the battle on my hands around remaining kind of resilient within the NHS. (63-67)

P8 here appears to be talking about resilience by describing it as a process that needs to be maintained, rather than as a personal ability. Moreover, it would appear that for P8 working effectively and 'feeling proud' of her work represents a sort of conflict.

Other participants, like P8, highlighted that resilience was understood as a process whereby the difficulty in sustaining resilience was conceived to be in the organisational environment and thus, placed outside the person. For example, P4

stated:

> And whilst I think it is important for us all to think about our own wellbeing and resilience, I just think the proof is in the pudding in terms of the staff turnover, how many people leave and how many people go off sick. (937-944)

P4's comment seems to carry the implication that the working environment presented the real problem to maintaining resilience. It would seem that for participants who conceived resilience as consequential of a process, resilience was negotiated in the space between the practitioner and the organisation. Further, arguably, participants who conceptualised resilience as a process indicated a certain level of struggle. This is not evident in the comments of participants who viewed resilience as an ability. This seems to propose that their experience of the environment shaped their individual understanding of resilience.

Some participants' responses indicated that practitioners considered resilience as something that is not talked about enough in the context of practitioners' wellbeing. For example, P8 contended:

> There needs to be more of a focus on staff wellbeing, which includes psychologists, psychologists not being just the ones who are delivering how staff can look after themselves, but they're actually living more by those values themselves, but they're also being supported to live by those values. (1164-1172)

Hence, P8 argues there was a lack of interest in focusing on psychologists' wellbeing and seems to state that psychologists are expected to assist other staff members and end up neglecting their own wellbeing since they are unsupported by their working environment. Other participants agreed.

Meanwhile, other participants described their understanding of resilience in

the NHS work context directly, along with the way the organisation's seemed to view it; for example, P10 said:

> We had this team away day recently, and we started talking about wellbeing, and the attitude was completely 'I don't want to hear how stressed you are'. And they actually chose to talk about resilience in a way … they weaponised resilience, like this is your duty, this is up to you, you have to, it's only you who can become resilient in the context of these horrendous stress levels, I think it's disingenuous and really, you know, it made me hate the organisation even more. (556-566)

Therefore, P10 seems to believe that the resilience concept was used to blame practitioners for mismanaging their challenges, thus citing practitioners' clear responsibility for their handling of these issues. Extending this, I interpret P10's comment as saying that she did not feel valued or supported by the organisation.

Moreover, since participants appeared to understand resilience as an ability or as a process, this seemed to draw out a dialectic of whether practitioners located the problem in the individual or in the social context of the environment. This, as well as its implications in sustaining resilience, is reviewed in the next category.

5.4.2 Category: Locating the Difficulty

While all participants talked about the challenging environment of today's NHS characterised by limited resources and large caseloads, they seemed to differ in their opinion on the real location of the problem. That is, whether the challenges practitioners experience maintaining their resilience are viewed as a resulting from a problem regarding the individual's resilience, or a problem in the external environment. Thus, this category denotes where participants located the strain; whether they conceived it to be within the environment or within the individual.

Interestingly, although almost every participant considered themselves resilient, there were differences in their view of whether they felt they were managing. Whether someone was managing or not, is a concept I used to describe whether participants felt that were coping, without having a negative impact on their wellbeing.

Participants who appeared to be managing well, located the difficulties within the person, whereas those reporting struggles identified the difficulties within the environment. This seems to be determined by their experience of the organisational context. This category comprises two primary sub-categories: *Within the environment* and *Within the person*, as follows.

5.4.2.1 Primary Sub-Category: Within the Environment. Several participants spoke of their difficulties in working within the NHS, portraying them in a manner that seemed to suggest they see these difficulties as characteristics within the environment. Nevertheless, when participants described these difficulties they encountered, they appeared to do so for different reasons. Some participants talked generally about struggling with the dynamics and structural characteristics of such an institution. For example, P7 revealed:

> I think the fantasy is that one could experience the vicarious trauma or the mirroring distress of your patient but when you come out of the room, you can let that go. But that only feels like part of it because, if I'm honest, that's the least difficult part of my job. And I think the part that is really difficult is to be able to cope with is the structural systemic pressures in the NHS and what resilience looks like around that, I don't know. (90-99)

P7 seems to view coping with the structural systemic pressures of the NHS organisational environment, as comprising the main challenge to sustaining resilience, more than client work-related challenges. Other participants reported similar

struggles. From this, it would appear that systemic pressures represented the main reason for participants' perception of the strain within the environment. However, P10 stated:

> The messages all the time "you're not good enough" "you're bad" that actually rubs on you even if you're a Psychologist or Psychotherapist or whatever, it really rubs on you, so I had a really difficult … one month, I was in total crisis. I was bursting into tears all the time. I was actually feeling that I was weak and I was feeling almost that they were right, if I'm not meeting whatever is necessary of me maybe it's true. (295-308)

Evidently, P10 did not feel valued by the context, but actually the overall message received from the environment led to P10 doubting her practitioner abilities. It would seem that P10's working manner was not consistent with that of the organisation. This also applied to P7. P7 stated:

> That's literally all I would do is sit and look at waiting lists and try to find reasons to say no to people because we just didn't have the resources to manage the numbers. And so, and then you get the people that you finally, they've managed to get through the door, they're in that perfect little sweet spot where they're well enough to be able to make use of therapy, they're not too unwell, they're not using drugs, they're willing and they haven't fucked up their track record of dropping out of therapy, that perfect patient, you then get, "Could you see them for 12 sessions in a group?" And that's just the reality, I think of NHS work, and that's not what we trained for, it's soul-destroying. (386-401)

It would seem that P7 is complaining of not being able to place the client's needs at the centre of the work. P7 seems to regret that the work has become centred

around trying to identify reasons to turn patients away. Both these participants seemed to feel that they were unable to offer clients what they needed, and feel completely annihilated in their work. P10 felt undermined and 'not good enough', whilst P7 seemed to feel she was working in a way that was 'not what we trained for'. Hence, the issue seems fixed within the organisational context.

Notably, the three counselling psychologists in the participant sample, all seemed to conceive the issue to be located within the environment, alongside the consequent challenge of working in an environment having a different ethos from that of their professional role. For example, P6 argued:

> It is very much a clinical psychology ethos which means that, for our professional identity, we are very much always having to straddle how we think as clinicians, which is in a very counselling, holistic way, working in an environment that is worked within the NICE guidelines. (42-49)

From this it could be suggested that P6 did not feel the professional values that guided her practice as counselling psychologist were compatible with the 'clinical psychology' ethos of the organisation. Another counselling psychologist (P8) compared the experience of working in her previous and current NHS services as follows:

> So, in my previous trust, it was very much cognitive behavioural therapy, EMDR, as the main focuses. And I did feel that that was because there was possibly a bit more of a medical appeal to the way that, you know, the approach, again the kind of solution-focused, somewhat tidy idea of how you can kind of do these things. And I felt that there wasn't as much focus on the things that I would hold true. (861-872)

This comment highlights P8's difficulties working in a manner incongruent with what P8 'would hold true'. Continuing the comparison, P8 stated:

> It's easier here because of the models we work to, because we work with acceptance and commitment therapy and we work with compassion-focused therapy. The model of therapy I feel aligns better with my principles as a counselling psychologist. So, I think that's possibly what makes it easier sometimes as well. (978-987)

In sum, P6 and P8, as counselling psychologists, considered that working according to their professional values was what facilitated working within this context. Further, from these accounts it would appear that when there were discrepancies between the practitioner's values and the organisation's ethos, participants tended to conceive the challenges to maintain their resilience as resulting from the external environment. When speaking of the organisational context in these terms, participants did not talk about the emotional impact of client work as problematic, or as an issue to their resilience. Yet, this was very different for participants locating the strain within the person, as seen in the next primary sub-category.

5.4.2.2 Primary Sub-Category: Within the Person. A number of participants felt that individuals were unable to sustain their resilience when they lacked certain skills or personal qualities. For these participants, problems in maintaining resilience seemed to centre mainly around their client work. For example, P3 said:

> I think mental health, particularly, requires you to be resilient because of the emotional impact of the people that we're working with. I think it's inevitable that your work does impact on your wellbeing to some extent. So, I think,

mostly, for me, personally, the biggest impact is just kind of stress and tiredness. (297-314)

For this participant, the principal issue related to the nature of client work and the stress and fatigue deriving from it. For this participant, the organisational dynamics and ethos of the organisation did not represent a problem, and likewise for other practitioners who located the issue within the person. For example, P5 indicated:

And people are appreciative of what you do, so I think that, as well, helps. Yes, so they might not say it, but you know it is appreciated, so that tells you something, you don't mind doing a little bit more. (599-611)

P5 seemed to be conveying the sense of feeling valued and appreciated for her work. Based on the preceding findings it could be suggested that how participants understood the causal locus of their challenges, reflected an unspoken relationship between the practitioner and the organisation. Although, participants did not explicitly talk about their relationship to the NHS, it seems each participant negotiated a particular relationship to the institution. This relationship seems to be moulded by multiple factors, such as whether or not the practitioner perceived any discrepancies between their professional identity, values and organisation's ethos, as well as their perception of the organisational environment. How the individual's perception of their organisational environment relates to how they understand the causal locus of the difficulty is explored further in the next category. Where practitioners seemed to locate the difficulty seems also to delineate the kind of coping strategies employed to overcome the challenges of this context.

5.4.3 Category: Perception of the Organisational Environment

This category denotes specific aspects of the organisational environment described by participants as helpful in supporting resilience. The two aspects identified are explored as primary sub-categories: *Perceived support* and *Perceived control*.

5.4.3.1 Primary Sub-Category: Perceived Support. This details participants' experience of support. Feeling supported seem to play an important role in sustaining practitioners' resilience, and there is clear accentuation on feeling heard, and knowing support will be provided when requested. This category is viewed through two secondary sub-categories: *Support from the team* and *Support from the organisation*.

5.4.3.1.1 Secondary Sub-Category: Support from the Team. When participants talked about perceived support within the organisational environment, evidently most participants described it as issuing from their team. P2 said:

> I've got colleagues here who are incredibly supportive and lovely so that if I have a challenging session, even if I haven't got supervision for a bit, I've got colleagues who can say that was really tough and they can support me. (164-171)

P2 mentioned supportive colleagues and for P2, support seemed to take the form of being listened to and understood. P5 agreed:

> I think always knowing that if you go to someone and say, "Look, I need help" then help is going to be provided, that helps you to actually hang in there for a little bit longer and the support is going to be there. (590-599)

P5's comments apparently supplement the dimension of support narrated by P2. In fact, it would seem that what P5 found supportive was the knowledge that support would be offered if requested. There is also the indication that P5 felt

reassured that any struggles would be shared in an environment where asking for support was possible and perhaps encouraged. Most participants indicated their experiences of support within their teams in these terms; however, P7 said:

> My experience of how difficult things are dealt within the NHS. You know, when there is difficult things, it's either ignored or mishandled and if you say anything about that, you end up in the shit and so I don't find it a very supportive environment. (814-819)

It seems that P7 did not consider the environment as supportive and struggled more to manage within this context. P7 appeared to be unassured when discussing, sharing this personal struggle, and when being open with the team, for fear that asking for such support would actually work against her. Similarly, P10 contended:

> I've sent so many emails. I'm really struggling I need help. I'm really struggling and I need help, and in this bullying incident on Friday, they ambushed me to go into a meeting at short notice and one of the things that I was told, I mean lots of different bullying incidents in that one hour, and I was told by two managers it is not our job to help you. (103-111)

P10 seemingly conveys a strong sense of conflict, attempting to reach out for support but all efforts were rejected. P10 would appear to interpret this as bullying and being ignored.

5.4.3.1.2 Secondary Sub-Category: Support from the Organisation. This details participants' organisational support experiences. Some participants made general comments when narrating their perception of the organisation's support, like "I think it helped that whatever I did was welcomed" (P5, 906-909), which conveyed a sense of appreciation for work performed. I interpreted this as P5 acknowledging

receipt of a certain degree of support. However, other participants, for example, P8, complained:

> You're just expecting us to do it and you don't want to hear us complaining about it, and we feel that we're being treated differently than nursing or the social workers or, you know, and that just feels quite unfair. And it just didn't feel like it was being heard. (770-775)

P8 portrays a sense of "us vs them", where "us" represented the team and "them" the institution. It also describes an experience characterised by a sense of not being 'heard'; one that did not promote a message of openness to discussion, and consequently resulted in a lack of support. Other participants agreed. For example, P10 said:

> At the moment staff wellbeing is not valued. They have to be perceived to mention these things but in practice they are really not listening. For example, in my place of employment they put together all these ideas for staff wellbeing without consulting the staff about what we need - is actually 'well we are going to tell you what to do' and resilience is mentioned sometimes in a very, in almost like an offensive way. (47-53)

Clearly then, P10 did not appear to experience the organisation as supportive. It highlights a discrepancy between what the organisation claimed in relation to staff support, and the reality. In a previous comment P10 described resilience as being 'weaponised' and used to place the responsibility on the practitioner, here she seems to reiterate the same concept. It might be speculated that the organisation might appear to appropriate the concept of 'resilience' and actively (if tacitly) use it to place responsibility on the individual for any difficulties being experienced due to a lack of resilience. This, might be seen as an organisational defence against recognising

something more fundamentally problematic with the system. Evidently, like P8, P10 seemed to draw a marked distinction between the organisation and the staff, where the organisation dictated what needed to be done, without accounting for practitioners' real needs. Additionally, P1 argued:

> I was just thinking about when, you know, my opinion wasn't sort of being valued around what I wanted or didn't want to be doing within my role and it's been kind of rather put upon me, I think that's when I felt less kind of valued and I think that kind of tested how I felt. (534-541)

Like P10, P1 does not seem to speak about staff wellbeing. Nevertheless, P1's comments apparently reveal that being ignored prevented her from perceiving support from the organisation. Further, P1 seems to state that her professional opinion was disregarded, and this resulted in not perceiving any decisional power within her role. As a result, P1 felt undermined, and this seemed to have a stronger impact on her sense of wellbeing. Arguably, on this evidence, it would seem that feeling undervalued equates to viewing the organisation as unsupportive.

Participants also appeared to describe that perceiving support resulted in perceiving a certain degree of autonomy and decisional power within their work, and this is discussed in-depth in the following sub-category.

5.4.3.2 Primary Sub-Category: Perceived Control. Here, participants' experiences of having autonomy and flexibility within their organisational context are detailed. Perceiving control within the organisational environment seemed to be helping practitioners sustain their resilience. This category consists of two secondary sub-categories: *Within their role* and *Within their teams*.

5.4.3.2.1 Secondary sub-category: Within their Role. Several participants

talked about possessing a certain degree of autonomy within their role, for example, P5 stated:

> Luckily, that's another thing, I book my own clients. So, I can do whatever I want in a way, so sometimes telling yourself this, I've got control of managing my own time, I can change things if they don't work. (724-733)

P5 speaks about a feeling of satisfaction that her role allows her to manage her own caseload and schedule. 'Doing whatever I want' enables her to feel in control, facilitating a sense of personal and professional autonomy. This facilitated the work, despite challenges. Nevertheless, other participants, like P1, claimed:

> One of the things that's set my sense of resilience is when … how that supervision is used gets imposed by others. At times, there's things that have come out of, you have to do this in supervision, you have to fill in this form, or you have to make sure that you've ticked off X, Y and Z, if you've completed all your mandatory statutory training, it's all up-to-date. And you think that's not how I want to use my supervision time, I want to be able to think about this, this, and this - this is what's important to me, and yet, you're telling me how to use my supervision. (601-612)

While P5 feels a sense of autonomy and control, others feel that control is all too readily taken away - for example where supervision time is taken up with bureaucracy and administrative tasks. A lack of control within their role seems to have a negative impact on the participant sense of resilience.

In sum, possessing autonomy within their roles seems to assist participants to sustain resilience, as it could enable practitioners to deal with context challenges effectively.

5.4.3.2.2 Secondary Sub-Category: Within their Team. Participants also discussed their experiences of possessing autonomy and thus flexibility, and hence the possibility to change practice inadequacies within their wider team. This also seem to contribute to sustain practitioner's resilience. For example, P8 said:

> None of us were particularly happy about that, you know, we feel that one of the things that we offer at xxx is quite a personalised, individual approach, and that's often what patients haven't received so much and so we felt that kind of makes a big difference but we had to look at the statistics and we're just like, we're not doing it, patients are getting reports later than they should. And so that was one of the things, we were actually looking at, as a team, discussing how we can resolve these sorts of issues that are shared issues amongst us. (649-661)

P8 seemed to believe that issues could be discussed as a team and solutions found. Having such flexibility and autonomy within the boundaries of the team, would appear to allow P8 to resolve problematic aspects of the professional role. It would seem that this arrangement enabled P8 to work in her own professional manner, according to what she perceived more appropriate. Other participants agreed. For example, P6 said:

> I suppose what I'm saying is, I don't like rigidity, a lack of flexibility and that can be difficult in a big institution, to be able to work in a way that you feel is beneficial to you as a practitioner and beneficial to the client as well. So, I suppose it's constantly about me and the client, so it's that sort of therapeutic relationship and everything else around it needing to be flexible to make sure that you can work well. (524-540)

It would appear that P6 argued that flexibility infers autonomy, and it would

appear that possessing this flexibility enabled P6 to work in a manner that she perceived to be beneficial to practitioner and client. I believe that with this comment P6 touched on the involvement of her professional values through working in a way that was congruent with the role's values, where the therapeutic relationship was prioritised. However, not all participants noted personal control within their wider teams. For instance, P1 reported:

> This idea that you should see x many people, have this many contacts, it's something that has been monitored very, kind of, quite a scrutinising way that I found very unpleasant. It rather feels that the work that we do gets forgotten, that it isn't just about the face-to-face or the phone calls, there's so much of what we add and do in value as indirect working. And it feels a real struggle that the system doesn't really … isn't almost set up to understand and appreciate what we do. (214-234)

P1 commented on the kind of expectations she perceives from the organisation highlighting the lack of personal autonomy within the work, feeling controlled and scrutinised by the organisation. Work value was apparently undermined and emphasis was given to contact quantities and not clients' needs. Similar to P10, P1 seems to feel undervalued as a practitioner amid little trust from the organisation. Possibly, this effect resulted from these participants' manner of working mismatching that of the organisation and being compelled to work in a manner alien to their own professional values. As P10 explains:

> That's your job. Seeing as many people as possible in as short a time as possible but the message is we don't really care about the people you see, what we care is the numbers at the end of the month and I started seeing that more and more as almost like fraudulent almost, that we're being coached on

what to do on the last session, so you have to do as much as you can to get people into recovery, whether it's realistic or not. So, to me that is actually thoroughly unethical. (1257-1272)

P10 portrays feeling dictated to and imposed on by the organization, particularly in relation to work methods that P10 seems to consider unethical.

In sum, when given support and autonomous control over their work practices, practitioners seem assisted to sustain their resilience. With support and control they appear to feel valued and can work according to their individual professional values, and prioritise their clients' needs.

Participants' environment perceptions seem to structure their relationship to the organisation and determines exactly where the practitioner pinpoints the difficulty in sustaining resilience. Factors that seems to have a bearing on whether the practitioner perceives support and control is explored in-depth later in the chapter.

5.4.4 Category: Strategies to Support Resilience

This category describes some of the strategies that participants drew on to support themselves and which appeared to facilitate their resilience. It explores some of the methods they used to access support, and describes how these methods seemed to amplify a sense of control both in relation to the work environment and to participants' own stress levels. The category is composed of three primary sub-categories: *Active coping strategies*; *Attitude to situation*, and *Attitude to self*.

5.4.4.1 Primary Sub-Category: Active Coping Strategies. This category depicts activities and strategies that participants engaged in that appeared to support resilience. I have used the word "active" to convey the sense that a certain level of effort and/or intention is required for participants to engage in these strategies. This

primary sub-category is illustrated through two secondary subcategories: *Practical strategies* and *Psychological strategies*.

5.4.4.1.1 Secondary Sub-Category: Practical Strategies. Some of the strategies described by practitioners were partially related to the individual's personal characteristics. For example, P3 commented:

> I think one thing that does help me to manage my stress is being organised about my work and organised about my time and things like writing to-do lists and ticking things off, then putting time in my diary, whether I can do that and planning my week. Those things do help me feel less stressed, because I just feel more on top of what I'm doing and less overwhelmed. Sometimes I'm resorting to colour-coding my to-do list into red, what needs to be done straightaway, orange, what's important but doesn't need to be done now, and then I leave the other bits. Because that does help me feel more in control of what I have to do. (492-518)

P3 seems to seek organisation of the workload to permit work and time control and to prevent overwhelming personal emotions. Moreover, it would appear there was a certain degree of proactivity in this form of weekly organisation which seemed to promote a sense of control that has been evidenced as significant when sustaining resilience. Meanwhile, most participants noted their engagement in specific activities, like participating in regular exercise. For example, P2 said:

> I do Pilates once a week and I do notice if I haven't done it that I feel a lot worse for not having done it. And if I have a week, because I also do Zumba on a Friday because I don't work Fridays, and I do notice now if I don't do my Pilates or Zumba then I feel much worse for it. I notice that I feel a lot more stressed. (379-386)

For P2 then, it appears that physical exercise had an essential positive impact on individual stress levels. Similarly, P3 said:

> So, from here, I kind of cycle, basically, part of my way home and then get on the train for the rest of the journey and even just doing that, leaving here and doing some exercise, I think is a really good stress reliever and is a really good way of switching off, getting into a bit of a different headspace. I think leaving and doing something different is a really helpful way of just switching off and relaxing, helping for that separation. (534-537)

Physical exercise seems to enable P3 to leave work behind and promoting a de-stressing effect in the form of a separation between work and private life. Other participants talked about the use of boundaries between private and work life, for example, P1 noted:

> We need to have real, clear boundaries, of knowing them and being able to set them and stick to them, you know, little things like my NHS email, I'm only two days and I'm two consecutive days so at the end of my second day I put my out of office on that says, please note, I only work two days a week so I'm not available now, I will only be able to respond to this on my next working day, which is next week. Others in my position don't do that and at times I think I'm too firm there. So, I do that. And, actually, for me it works. (445-475)

Thus, P1 relinquished work-related matters outside of working hours, and this action seems to be valued as a means of sustaining resilience. This also seem to reveal some assertiveness when setting and maintaining boundaries. Other participants championed the importance of leaving work behind, thus keeping a good work-life balance. There is an apparent emphasis on participants being able to disengage from

all work-related matters to avoid the negative emotional impact of client work.

Hence, for these participants, using these strategies is adequate for sustaining resilience. Nevertheless, practical active strategies were not enough to overcome the type of difficulties that P7 was facing, reporting:

> I know what my coping strategies should be, I know that I should go to the gym and I should talk to my friends and I should make all like fun plans and do crafty things. As it happens, I do those things but I do them because I know that the research says that they work. If I'm honest, the thing that I do the most to calm myself down and relax is either eat cake or watch TV on my own in my room. (21-28)

Participants like P3, who found these strategies particularly helpful were mostly referring to client work stresses. For P7, however client work seemingly did not represent an issue; instead, the conflict between organisational dynamics and practitioners' professional values appeared more evident. Here, such strategy use appears less effective.

In sum, these strategy types were helpful when dealing with stress, and the emotional impact of client work, but were more redundant when the practitioner was fraught with the issue of negative organisational dynamics. Additionally, these strategies were selected by participants struggling less and by those who were managing (even if used slightly less) to sustain resilience within this context. Conversely, these strategies were rarely used by the participants who were not managing (Appendix AB). These findings highlight the prominence of these strategic activities when participants sustained resilience.

5.4.4.1.2 Secondary sub-category: Psychological strategies. While some participants clearly benefited from engaging in practical strategies enabling them to

distance themselves from the emotional impact of work, others discussed the way in which they deployed psychologically-oriented coping techniques to help them manage their work-related stress. Several participants reported the benefits of remaining in the present. For example, P9 contended "I try and focus on the present, so I tend not to go down the catastrophising route or to really predict into the future. It's very much about what's going on right now" (836-841). For P9, focusing on the task at hand, thus prioritising the present moment, proved to be a useful strategy. Other participants seemed to describe specific cognitive strategies that helped them stay in the present. For example, P4 commented "I find mindfulness really helps, particularly noticing physically when I'm starting to get stressed" (354-357).

These strategies seemed to be effective for some participants, mainly for those who sought relief from work stress. Yet, they were insufficient regarding overcoming issues related to organisational dynamics and social context. To illustrate, although P4 seemed to recognise the benefit of practising mindfulness, this participant commented "It is a really stressful environment and it's not going to be fixed by doing some mindfulness techniques. That helps, but it's not going to fix the operations" (948-953).

5.4.4.2 Primary Sub-Category: Attitude to Situation. This category denotes practitioners' attitudes adopted when appraising and responding to different situations. Such attitudes appeared to help them manage the emotional impact of this context. For example, P5 said:

> But you need this as well with clients because you can't change their lives, you can make a small difference, but if they've got £500,000 debt, well it's a consequence of their behaviour, they have to accept it, they have to cope with it. If the wife is separating from them, well, very sad, they can't see their kids,

> but you can make a difference to their behaviour, their present and their future, so it's being mindful of actually what you can do, what you can't do. (742-764)

P5 seemingly adopts a realistic approach to client work, recognising that to make a difference depends on the circumstances of the client. Also, P5 appears to accept that the difference might be very limited. Other participants reported a similar attitude to client work. As P9 commented:

> I've never lost sleep over a client. And I like to think that's not because I'm not empathic, and it's not because I can't empathise with their position, I just don't see the point in torturing myself about it. You know, I do absolutely the best I can for them in a work situation but I'm only human, I can't do it all. (93-99)

While P9 evidently has a realistic approach to the amount attainable for clients, they also seem to accept that the work is too complex to achieve all client goals. Other participants acknowledged the realistic necessity of inevitable limitations to optimum achievement. For example, P1 said "You know, if despite your values, you're not feeling good or you're feeling it's too much, you can't do it all" (436-438).

P1 expressed a slightly different meaning here to P9, despite some acceptance of what could be done, P1 appeared to struggle with this. I believe this again interlinks the concept of professional values. Indeed, some participants floundered precisely because they were unable to help clients sufficiently. For example, P4 argued:

> Sometimes we get people who want you to fix things that wouldn't meet our criteria, that can be frustrating as well. I think those days, I find my resilience wanes a little bit because I don't enjoy it and I find it really hard because I

can't offer much. (660-669)

It might be argued that some therapists who may have gone into the profession in order to help, or even rescue clients, find it particularly difficult when they can't. Indeed, when they 'can't offer much' (or as much as they thought they could/should) as in the case of P4, perhaps their sense of efficacy and professionalism is then further (or more easily) undermined by the system that tells them 'you're no good'.

This might create a tension between their perceived 'role' as psychologist and how they are required to work. Here, P4 introduces a further level of values, related to enabling the client to improve. Similarly, P7 said:

> And that's what I see with my colleagues, you know, I see them losing their shit but it's not because their patients are difficult, it's because they can't get their patients the right treatment. They want to get them here, they can't because there's no money for that. (522-529)

Echoing P4's statement, P7 seems to convey a similar sense of frustration at being unable to offer the type of care to clients that they would conceive as appropriate. This seems to reflect a discrepancy between their practice within the service and what they believe is the purpose of their role. It could be deduced from this that when a practitioner holds a realistic attitude to what can be achieved, whilst also accepting that not every client can be helped, the tension described above between their perceived role as psychologist and how they are required to work seems to dissipate.

P4 and P7 felt that they could not "offer much" to clients due to the organisation's resources and set up, and this would seem to have an impact on their resilience. Alternatively, P5 and P9 referred to challenging situations strictly connected to the client's situation; thus, it would seem that these participants did not

believe organisational dynamics and restrictions represented a problem in their work. This might intimate that their manner of practising and conceiving client work, was consistent with both their perception of their role values and with the manner in which the organisation conceived such work. Further, when speaking of how being realistic was a helpful coping mechanism within this context, P11 considered:

> I think probably another way of coping is I have worked in private practice from quite early on so this made it easier because I knew I had NHS work and I had the private practice so I knew that maybe NHS was kind of sometimes dealing with autonomy more, but I knew I had private practice if I wanted to be more creative with clinical work, so this helped me keep the balance. I didn't feel that the role in the NHS was just for me developing my interest, I felt it was also working in a particular service context and was very realistic about, you know, about meeting the service demands, and ticking these boxes a lot of the time while finding other ways to keep thinking space, and my values, alive. (243-255)

Here, P11 apparently approaches a realistic attitude to work from a slightly different angle. P11 described having a realistic attitude to what the role in this context might have been, which seemed to help manage the discrepancy between personal practice within the service and the professional role. It would seem that P11 considered professional autonomy vital in sustaining resilience and to be able to employ self-selected theoretical models appropriate to the specific client situation, which could be also seen as working according to her professional values. This could occur outside the NHS environment, but it needed to occur if P11 could reconcile organisational limitations in the work context. This then, accentuates the value of working according to professional values when sustaining practitioners' resilience.

Some participants also seemed to acknowledge some traits they possessed that contributed to their individual response to challenges such having a naturally calm personality.

In sum, these participants illustrate that these kinds of attitudes towards situations seemed to support practitioners to manage the emotional impact of client work, together with the reality of the organisational context and its dynamics. Such attitudes provided again, a personal sense of control of their own emotional reactions, and a measure of support. Participants were more realistic and self-forgiving of what they could do, such that they did not pressurise themselves to achieve the unattainable. Still, not all participants could develop this attitude because acquiring it relied on their individual set of values, if these fully aligned with the manner of their practice, and if they connected with the organisation's manner of conceiving client work.

Notably, in a similar manner to the active coping strategies described previously, these "attitudes" towards client work seemed to be mainly used by practitioners who could manage better within this context. They were not, however, used by those participants who were not managing (Appendix AB).

5.4.4.3 Primary Sub-Category: Attitude to Self. This category reviews the manner in which practitioners relate to their own self. Almost all participants talked about monitoring their feelings. According to P1:

> I do actively and consciously check in with myself and keep an eye on myself in terms of: how am I doing? I try not to kind of have my head in the sand and just keep going on regardless. I feel like I have no … my body and mind and emotions saying, "oh, I'm really struggling right now I'm having a hard time,

or, oh, okay". I need to recognise how I'm feeling and look at what I'm doing. (386-410)

P1 seems to portray self-awareness of individual feelings and stress levels, and held an internal dialogue to monitor progress. This infers self-awareness of her needs. While acknowledging the importance of self-awareness, other participants, like P8, remarked:

> As a counselling psychologist, and again, I can only say that from a biased point of view, I suppose, having done the training I've done, I think all the work that we do, personal therapy, experiential groups as our training, there's an awful lot of exposure to awareness of one's self and who you are, what you bring, when it's a problem, what makes the difference. (1292-1300)

Here P8 appears to describe having a self-reflexive stance. This was attributed to the counselling psychologist training. Other participants found self-reflection particularly valuable.

Interestingly, this emphasis on a reflective/reflexive stance was only raised by participants who believed they were managing but struggling and was not highlighted by those participants who experienced comparatively little difficulty in sustaining their resilience within the NHS (Appendix AB). Further, all the counselling psychologists in the participant sample possessed a self-reflective attitude. This suggests there may be differences in how participants sustain their resilience, and that they engage in different types of activity depending on the nature of their professional training. However, few of the clinical psychologists in the sample also seemed to be particularly keen on engaging in reflecting activities.

Whether participants who managed well did not engage in such reflective activities because they did not perceive a problem and therefore found less need to do

so, or they did not perceive a problem because they did not engage in such reflexive approaches, is later explored.

Moreover, most participants described having a kind relationship with themselves. For example, P8 commented:

> Because a lot of psychologists I work with, or trainees or assistants, are very hard on themselves. They're very worried about getting it wrong. And they're very worried about appearing that maybe they're not coping and I'm like, "You know, you've got a personal issue going on, you've got something that's stressing you out," or whether it's the course or whatever, you know. Acknowledge that, be fair to yourself, you know, validate the fact that, you know, just like you'd support a patient or a client that was struggling, or a colleague, you count in that too, you're not a different species, you know that's the same for you. (1105-1118)

P8 seems to contend that practitioners should be as compassionate towards themselves as they would be with clients and colleagues. Similarly, other participants also showed understanding towards themselves, for example, P5 said:

> Saying to yourself, if it can't be done, it can't be done, there is nothing you can do … that sense of process is part of this, so you almost have to say to yourself, "You are not responsible for this". (506-514)

What P5 comment seems to be suggesting is that being understanding and compassionate towards oneself, could assist practitioners to accept that it is impossible to help everyone and still convey a realistic sense of the situation. Additionally, this could play a part in helping practitioners maintain a sense of calm without being overwhelmed by difficult circumstances, thus enabling them to perceive a sense of control.

As previously stated, engaging in active coping strategies and adopting specific attitudes to situations were strategies mainly used by practitioners who could manage better within this context. In contrast, this more reflective attitude, and deeper engagement with their self, was characteristic of participants who were managing but still reported struggling within this context. Interestingly, this engagement with self was also characteristics of practitioners who were not managing within this context (Appendix AB).

In sum, it is arguable that participants who felt their values contrasted with the manner in which they practised within the service, and thus with the organisation's values, could have developed a clearer picture of their inner values. This is because their set of inner values would be constantly tested against the values of an organisation that was perceived to have a very different ethos from that of participants' professional identity; not only for the participant counselling psychologists, but also for those participant clinical psychologists who believed their personal values did not align with the organisation's values and the manner in which they were asked to practice. Therefore, consequential to this conflict, and holding a more defined idea of their inner values, participants could have identified the need to engage more in reflective/reflexive practice, compared to those participants who did not perceive this conflict.

Meanwhile, it is possible participants who were not struggling to sustain their resilience within this context, did not engage in such reflective activities as frequently because their professional value set aligned completely with the organisation's values and perhaps this did not represent a conflict. The result could be a less defined image of their set of inner values, because these would interlock with the manner in which

these participants worked, with little effort required to self-reflect to balance their values and their manner of practice.

5.4.5 Category: Meaning

This delineates participants' main reason for working within the organisation, and helping them sustaining their resilience despite challenges. This category is explored via two primary sub-categories: *Doing something of personal value* and *Making a difference*.

5.4.5.1 Primary Sub-Category: Doing Something of Personal Value. All participants spoke of their work as meaningful and uniquely valued by them. This was the main reason participants reported for remaining working in such a challenging context. This primary sub-category describes what participants felt about their work and what it meant. For example, P6 said:

> So, for me, the option was not to leave, but to try and stay a bit longer because I have developed something here and it was something that was very special for me to do. And so, to continue being connected to that, I needed to try and stay in some form possible. (352-360)

Thus, P6 seems to believe that work developed within the service was personally valuable and should not be left behind. Another participant, P8, stated:

> The likelihood that people remain resilient, that they continue to work in the face of adversity is much more likely to be the case when you're doing something that matters to you. So, whether it's something that matters to you personally or professionally or it's because it matters to somebody who's important to you and that's why you value it. I think it's probably, there's probably a strong connection between the amount of resilience that you have for something or for someone and how much you value it. (34-38)

Here P8 apparently identified a link between resilience and doing work that is personally valued, emphasising the significance that working with meaning had regarding sustaining resilience within this context. Similarly, P11 mentioned:

> You have the chance to make a change in people's lives and it can be very rewarding. To think it's such a vast field in psychology and therapy, there are so many things to learn, so if this is something that you didn't just fall into by accident, but something you wanted to do I think the content of the job can also be a way of kind of being resilient too, it's something that drives me because I think you need this to be able to survive this job. You need something to drive you and to make you feel like what you do has meaning, otherwise it can become very stressful. (446-464)

P11 appears to contend that contributing to positive change in people's lives made the work rewarding, this was closely connected with the feeling of making a difference, and supplies the 'drive' to continue. This is explored in the next sub-category. P11 also echoes P8's words, repeating the significance of doing work of personal value to sustain resilience within this context.

5.4.5.2 Primary Sub-Category: Making a Difference. This primary sub-category described a process by which participants seemed to develop their perception of meaning within their work. For example, P1 stated:

> Some of the work that you do and you can see the value and impact that it has and the difference it makes and having those sort of wins, I guess, I think it's incredibly important that … it reminds me of the times when it is trickier, okay, it's all right, I am still making a difference somewhere. (312-318)

P1 seems to argue the feeling of making a difference in clients' lives helps sustain their resilience. Most participants tended to describe this type of experience,

and in light of the findings in the previous sub-category, possibly practitioners believed their work was actively meaningful because they felt they were making a difference. Likewise, work that is personally valued by practitioners could inevitably culminate in the feeling that they improved clients' lives. However, P7 countered:

> When we train, it's very idealistic about whether you're going to be able to see somebody from total distress to the point of some kind of self-actualisation and really what you're up against is, in the NHS mostly, is you're taking people from … Freud had this quote about something about unmanageable distress to garden-variety distress. I don't even know if we get to garden-variety distress, I think we just try and keep people alive. And I don't know, I mean, in your training, is that what people are telling you? Are they telling you that if you work in the NHS in severe mental health that mostly your job is going to be trying to keep people alive and that to get into secondary mental health services you have to be so unwell that the gains you could make in therapy are tiny? (336-350)

P7 seems to be highlighting a discrepancy between her therapeutic ambitions and the reality she faces as a practitioner, expressing the disappointment she feels about her limited ability to help severely distressed clients; thus, not feeling making any difference in their lives. She doesn't seem to feel her training has prepared her for this discrepancy.

In sum, these findings suggest that if practitioners value their work, they felt rewarded, despite challenges. This was significant in sustaining practitioner resilience. However, practitioners sensed their work as meaningful only after feeling they were making a difference in clients' lives. What influences whether or not practitioners felt they were making a difference is explored in-depth in the following

core category.

5.4.6 Core category: Alignment of values

In the previous section, the tension between participants' perceptions of their role as psychologists and the demands placed upon them within the organisation, emerged as one of the main difficulties in sustaining resilience. One way of thinking about what might be going on is a conflict of values. The extent to which practitioners were managing within this context seemed to be mediated by the degree to which they felt that their manner of working was consistent with their professional values, and how these related to the organisation's values.

For example, in the foregoing sections, some participants referred to the tension between working in the manner which they conceived to be most appropriate to their role, and being valued and appreciated for their work within this context. This could be thought about in terms of a conflict of values, as the way of working they conceived as most appropriate would reflect their professional/personal values, and if this was not perceived as effective by the organisation, it could indicate a mismatch between the individual's and organisation's values. Likewise, the participants' location of the difficulty seemed to be depended on whether or not the practitioner felt valued, and this, in turn, relied on their values being consistent with the ethos of the organisation.

Furthermore, I have discussed how perceiving the organisational environment as supportive, and one that allows the practitioner a degree of autonomy over their work support practitioners' resilience. One way of thinking about the differences in the participants' perception of the environment might be again in terms of values. In fact, when practitioners perceived organisational support and autonomous control, it might indicate that the values of the individual overlapped positively with the values

of the organisation; it might be speculated that the organisation trusted that practitioners would work according to its underlying set of values. Conversely, if practitioners could not detect such support and autonomous control, this could signify potential conflict. This is common when practitioners work in a manner inconsistent with the organisation's values, resulting in the organisation imposing control on their work practices and withdrawing practitioner autonomy. This, in turn, undermines practitioners' professional work, creating the sense of an unsupportive organisation.

This core category is illustrated via two primary sub-categories: *Working according to personal and professional values* and *Alignment of values between the individual and the organisation*.

5.4.6.1 Primary Sub-Category: Working According to Personal and Professional Values. This sub-category denotes the experience of working in a way that was or was not felt to be consistent with the standards and values of their role. For example, P8 states:

> As a psychologist, as soon as those sorts of limitations get put in, you question, am I going to be able to deliver in a way that, you know, I feel is ethical and that I feel that I'm actually doing certainly a decent enough job to make a difference here, or is this, bringing things into conflict that don't sit very well with me? And when that happens, for me certainly, my resilience gets tested. (266-274)

P8's resilience seems to have been tested when there was the belief that the quality of the work was compromised due to a lack of resources to a point that it did not meet standards individually perceived as ethical. It could be said that this reflects P8's professional values as a psychologist, working in an ethical manner to promote change in clients' distress levels, negatively contrasting with the manner required to

practice because of imposed organisational limitations. Other participants spoke more explicitly about this conflict between their professional values and NHS work. For example, P7 said "People are just leaving the NHS in droves because, because it doesn't feel like it fits with the values of our profession anymore" (424-426). This tension between participants' professional values and the manner in which they practise reared itself once more. However, it was present for some participants, but not others. For example, P3 noted:

> Yes, and I think that aligns with my values as a person, so I feel like what I'm doing with my day-to-day life is aligned with the things that are important to me, the things that I care about, it's how I would want to be living my life, it's doing something that I feel like is contributing and is making a difference. (691-700)

For P3, the work seemed to align with personal values, and did not convey the sense of struggle that transpired from P7's account. Further, while P7 referred to professional values, P3 spoke of personal values. This could question the difference between practitioners' personal and professional values. P11 seemed to address this difference, stating:

> I think it's like you value, I don't know, being caring, for example, or being authentic, or having a high integrity, or you value people's opinion and kind of promoting independence and helping people develop. This is something that you value as a person and then you may value as a psychologist, and then you may value as a leader. So, I think they do go together. (190-196)

P11 apparently indicates that personal and professional values should overlap, as seemed to be the case for P3. Possibly, the practitioner's personal values are established by that individual, whereas professional values are negotiated and

established in relation to external influences like role, profession, training, or a combination of these. It could be said that personal values refer to a unique and individual set of individual values that are constructed through social interaction throughout one's life. By extension, it could be argued that an individual's professional values are constructed through social interactions during their training and within their working environment. Thus, each individual possesses a secret set of values to follow that is the result of their constructed personal and professional values, and the extent to which practitioners are true to these inner values, influences how well they manage within this context.

Within previous categories, the possibility of viewing the organisation as possessing values was aired, and while the personal values of the individual should overlap with their professional values, this unique set of practitioner's inner values - which would guide the way in which they practise and conceive client work - may or may not overlap with the organisation's values. This created deep internal conflict as illustrated throughout this chapter, and is seen more in-depth in the next sub-category.

5.4.6.2 Primary Sub-Category: Alignment of Values between the Individual and the Organisation. This category illustrates an aspect of the practitioner-organisation's interaction, specifically it denotes the experience of participants who did not perceive their set of inner values as aligning with the organisation's values. This presented the largest obstacle to their resilience. For example, P10 argued:

> I'm living in this environment of work and it is starting to be so incredibly dissonant with myself and what I stand for that, you know, just going back to my values, like okay what's important for me, respect, kindness, compassion, wanting to help others and you're thinking but I always thought that those

were the values of my organisation as well, but I'm seeing that they are not at all. (508-517)

P10 did not appear to feel that personal values were the same values shared by the organisation, and this seemed to create a significant struggle when managing within this environment. This emphasises the pivotal importance of the alignment of values between individual and organisation in sustaining practitioner resilience. Similarly, P7 stated "It's the politics around that and people don't put the patient at the heart of that. They say they do but they don't really" (140-143).

P7 describes apparent difficulties inherent in working within an environment that did not match practitioners' manner of conceiving client work and their professional role.

Participants who managed well did not talk about the issue of not feeling working according to their values. Thus, it would appear that it did not represent a problem for these participants. It reiterates that if practitioners worked according to their professional values, and if these aligned with the values of the organisation, this was central to whether or not an individual sustained their resilience within this particular social context.

Chapter six

Discussion

6.1 Introduction

In this chapter I summarise my theory; I assess how my findings relate to the existing literature and to the NHS context; I then evaluate the quality of my study, and discuss its limitations and implications. I make recommendations for the future and for new avenues of research. I finally conclude with a reflexivity statement.

6.2 Brief Summary of the Grounded Theory

My theory suggested that practitioners were able to sustain their resilience within this context when there was an alignment of values. Specifically, the extent to which a practitioner's personal and professional values aligned with the values of their organisation, appeared to define practitioner's perception of the organisational environment, where they located the difficulty in sustaining resilience, as well as the type of coping strategies they used. Further, the extent to which these values aligned seemed to influence the level of perceived meaning participants experienced as a result of their work. All of these variables appeared to shape participants' understanding of resilience, understood either as a responsibility of the individual or contingent upon an interaction with the organisation.

6.3 Comparing the Findings with the Literature

The literature on practitioner's resilience reviewed at the beginning of this thesis mainly included research on individual characteristics, work-related stressors, coping strategies, self-care and burnout. However, the GT analysis promoted insights into the complex interactions between the practitioner and the organisation. In this

section, first I am going to provide an account of how my theory relates to the above-mentioned literature; then, I will discuss how my findings may apply to the current NHS context.

6.3.1 Theories of Resilience and Factors that Support Practitioner Wellbeing

My category *strategies to sustain resilience* accords with the theoretical model of resilience at work developed by Winwood and colleagues (2013) which conceptualises resilience as engaging in specific behaviours/attitudes that sustain the individual to recover from and manage the stresses of their work. However, this model differs from my theory as in these strategies are important but not enough to sustain practitioner's resilience and that the high-order concept *alignment of values* explains what mediates the effectiveness of these behaviours as well as their choice.

Evaluating my theory in relation to the literature on coping strategies, self-care and career sustaining behaviours, my theory accords with the notion that practical coping strategies, such as being pro-active, using problem-solving (e.g Ben-Zur & Michaell, 2007), seeking support (e.g Cramer et al., 2019), maintaining a work-life balance and boundaries (e.g Stevanovic & Rupert, 2004), developing-maintaining professional competencies through use of supervision, and/or personal therapy (e.g. Lawson & Mayer, 2011), maintaining their professional identity (e.g Rupert & Kent, 2007) using humour in their work (e.g Goncher et al., 2013) as well as engaging in activities such as physical exercise and mindfulness/meditation, are effective in supporting practitioners' wellbeing (e.g. Cramer et al., 2019). What my findings seem to add to this literature is that there is a difference between people who were managing and people who didn't feel were managing as much, in terms of choice of strategies, in a different way that is usually described. Indeed, the difference between people who managed and who struggle is often associated with the 'wrong' coping

strategies - avoidant strategies. Whereas here, the differences were linked to a closer relationship with their own self, suggesting a more reflective stance, as opposed to engaging in ineffective strategies.

Further, what I constructed as strategies, other authors constructed as being characteristics of the practitioner. For instance, my sub-categories 'attitude to the situation' and 'attitude to self' accord with the literature on individual characteristics of resilient/master therapists (Skovholt et al., 2004; Hou, 2015). However, my findings do not support the notion that age/experience is negatively associated with burnout (e.g. Ackerley et al. 1988). I constructed participants struggling, despite their many years of experience.

My theory also accords with the literature that suggests the involvement of values in sustaining practitioners' wellbeing. A study conducted by Veage and colleagues (2014), found that congruence between mental health practitioner's work-related values and their personal-life values, was associated with lower levels of burnout and higher levels of wellbeing. This sample of mental health practitioners upheld values that were congruent with the values that are commonly shared by caring professions. This seems to suggest that choosing a profession in which the personal values align with the values of the professional role, plays a part in sustaining practitioner's wellbeing. However, what my theory highlights is that it might not be enough to have congruence of values between the individual and the profession, but also whether or not these align with the values of the organisation in which they work plays a central part in sustaining their wellbeing (Towey-Swift & Wittington, 2019).

Finally, my findings support the literature that suggests the central role that both support and autonomy play in helping practitioners sustain their wellbeing (e.g.

Rupert et al., 2015), as well as highlights the importance that meaning and feeling of making a difference, have in sustaining practitioner resilience (e.g. Wright, 2017).

6.3.2 Theories of Burnout and Factors that Impact on Practitioner Wellbeing

Contrasting my findings with the literature on burnout, values seemed to be the overarching mediator of all the variables mentioned in such literature, as opposed to be one of the variables that contribute to practitioner's wellbeing, over and above workload and resources. In fact, the extent to which these variables were significant in sustaining practitioners, seemed to be mediated by the alignment of values between the individual and the organisation.

Further, my findings contribute to the dialectic in regard to whether resilience is considered a responsibility of the individual or has a more organisational connotation instead. My theory proposes another way of looking at this issue, suggesting that whether or not the practitioner and the organisation's values align, is what defines where the responsibility will be located by the individual. This may explain the different views on where the responsibility lies.

6.3.3 Implications to the NHS Context

The theory I constructed could be another way of thinking about Lawrence's (1977) theory which suggests using the concept of the primary task (Rice, 1963) as a tool to analyse what is happening within a given organisation. Interpreting my findings in this way, we could say that the primary task of the NHS - its values - is to provide mental health care for everyone, with a commitment to quality of care, providing support and safety and improving quality of life.

Is it possible that the values of the NHS have migrated away from where they used to be? It would appear that the environment that is developed, due to the introduction of neoliberal philosophies that have brought marketization into the NHS

(Ballatt & Campling, 2011) has led to a tacit change in the organisation's primary task, and this shift created a significant conflict between what the environment feels like to work in and the values it is said to uphold.

According to Lawrence's (1977) theory, when there is a change in the primary task, individuals that work for an organisation will be heavily affected as they continue to carry out their existential task - defined as the meaning they attribute to their role- which in this case could be seen as wanting to help clients pass from distress to wellbeing or making a difference. When people continue carrying out their existential task but there is a discrepancy between the task of the organisation and the individual, it leads to the development of conflict in remaining satisfied working within such an organisation (Lawrence, 1977). This could be thought of as a clash of values.

It makes sense to think that a clash of values would make it difficult for the practitioner to sustain their resilience, as values are what give meaning to our behaviour (Schwartz & Bilsky, 1987; Rokeach, 1973). It is important to choose a professional role whose values align with the individual's personal values (Veage et al.,2014). However, for the participants I interviewed it is not as simple as that. In fact, they chose to go into this profession because they have certain values, but from what they reported, they seem to feel tricked, as well as accused of not being good enough, because of their expectations of what working in such an organisation would be like.

Extensive organisational literature on recent changes to public sector services highlights the impact that structural and systemic changes with the introduction of neoliberal philosophies and regulation of performance in the public healthcare sector, had on the culture of care (e.g. Ballatt & Campling, 2011; Campling, 2014).

A targets-driven, market-led organisational culture, detach management from the reality of frontline working, focusing more on targets-meeting than on good client care (Francis, 2010; Healthcare Commission, 2007). This may result in not prioritising a therapeutic culture, pulling away from applied compassion (Ballatt & Campling, 2011). The unprecedented change in the organisation structure over the last decade, in this prolonged period of austerity (Dunn, et al., 2016; Gilburt, 2015), might have had a significant impact on the workforce, and possibly created ambivalence amongst staff. Change can be emotionally distressing and impacts on the individual's perception of their work, clients and colleagues (Ballatt & Campling, 2011). In caring professions, individuals tend to be attached to a specific manner of working, highly value their job and place significant attention in the service they offer (Ballatt & Campling, 2011). Some authors even conceptualised this constant change as a 'social defence' against the anxieties of healthcare work (e.g. Campling, 2014; Moylan, 1994; Dartington, 2004; Zaiger Roberts, 1994; Menzies Lyth, 1959).

It would appear that the complex mechanisms that brought the NHS to prioritise a 'target culture', are not only the result of the current socio-political context, but may also be the result of unconscious organisational dynamics that emerge as a defence against the anxiety of working with psychologically distressed or mentally ill individuals (Rizq, 2014). Drawing on the 'social defence' model, Rizq has drawn attention to current neoliberal philosophies underpinning organisational structures in the NHS that appear to disavow dependence and vulnerability in both staff and clients. In fact, there seems to be a complex interaction between government health related policy, organisational structure and unconscious dynamics (Rizq, 2013). It has been argued that recent government-approved initiatives have led to the development of mental health services which are characterised by an organisational

structure that promotes and reinforces the use of systems designed to constantly evaluate and monitor staff and clinical activity (Rizq, 2013). These systems are designed to promote and privilege activities that have the effect of disavowing the presence and extent of psychological suffering, and which prevent practitioners from prioritising the very care they are mandated to provide (Rizq 2014). In this way, the prevailing neoliberal philosophies that underpin organisational structures and systems in the NHS could be said to promote organisational defences that unconsciously protect staff from the anxiety of dealing with psychological distress and the very real limitations in their capacity to help (Rizq, 2013; Rizq and Jackson, 2019).

My study raises questions about whether the environment that has been created has to be like that, or whether there are unhelpful characteristics about the environment that might have been created by interacting with it. The issue then is less about whether the problem is located within the individual or the social context, and more about the interaction between the two. It would seem that in the mechanism of resilience in this socio-political context, there is an organisational component particular to the NHS which is linked to a much wider landscape. It appears that the changes within the NHS led participants to perceive resilience as their responsibility rather than the responsibility of the organisation they are working for.

What I proposed here, is an alternative construction of the issue of burnout and resilience among NHS practitioners that is not linked to the specific demands of the organisational environment or the resources/characteristics of the individual, but one that is maybe closer to the language psychologists often use, emphasising the important role that values play in our profession.

This emphasis on individualising approaches to resilience is also evidenced in the nature of resilience-related literature found prior conducting the CGT analysis. In fact, the literature presented in the literature review chapter, is rather characterised by a focus on the characteristics/resources of the individual, on factors that create difficulties for practitioners, and on different coping strategies used by practitioners to cope with the demands and stresses of the work. However, it does not focus on the interaction between the practitioner and the organisation.

This could be thought of as an effect of individualising approaches within psychology and the locus of emotional distress, which might have contributed to conceptualise mental distress - and therefore lack of resilience – as an individual issue and thus separate from the context and socio-political culture in which it occurs (Rizq, 2014). The idea that mental and emotional 'disorder' arises from difficulties in the individual rather than problems in the individual's environment and socio-political context is a significant issue for mental health services, which tend to focus on 'treating' the individual, rather than working to address the political problems that give rise to conditions that promote psychological distress such as poverty, deprivation, lack of opportunity, lack of family support and so on. My study locates the idea of resilience not (or not only) in the individual, but in the organisational context in which practitioners find themselves.

It could also be argued that the emphasis on 'fixing' the stress experienced by an individual through the use of approaches such as mindfulness, might be contributing to maintain the status quo, and it might therefore be important to reflect more on the limits of changing the 'self' to fit the environment instead. The issue of whether or not psychological therapy aims to help individuals 'adapt' to a problem

(toxic) environment, or whether it can help 'radicalise' individuals so that they are able to effect a change on that environment is a huge and complex question.

From the participant's accounts, it could be suggested that while some have found a way to deal with the consequences of these changes and accepted the way in which they are asked to work, others cannot. This may be dependent on their internal conceptualisation of the organisation (Armstrong, 2005) that shapes their perception of their work and role.

Further, the difference constructed in the analysis in regard to the perceived location of the difficulty in sustaining resilience between participants who considered themselves resilient and participants who did not might be understood in terms of the notion of subject positions (Davies & Harrè, 1990). In other words, do certain environments allow an individual to occupy the position of being resilient, or not allow them that? In fact, subject positions may be accepted, resisted, offered or claimed by people within a specific context and these positions emerge through discourse and dependent on the individuals understanding of such discourse (Davies & Harrè, 1990). Positioning could refer to the mechanism of constructing identity as resilient -or not- as well as defining the obligations, rights and possibilities that comes with that particular subject position (Davies & Harrè, 1990). This notion might help to explain participants' attitude towards the environment and towards their self within this specific context.

The clash of values that seemed to be experienced by some participants, where the values ingrained by their training felt to be at odds with the values of the organisation, may be seen as their training prioritising and encouraging a therapeutic culture of compassion based on the values of the caring profession - where client care

is at the centre of the work - and such culture being no longer prioritised within the NHS but rather a market-led one (Ballatt & Campling, 2011).

It could be argued, then, that the phenomenon of resilience within this context may have nothing to do with the resilience of the individual or the amount of resources available *per se*.

This might explain why the current interventions are not as effective as we had hoped in reducing distress among mental health practitioners, as evidenced by the trends in the latest surveys.

Is it possible that the current interventions are mostly about addressing the increase of individual internal resources or aimed at reducing organisational demands - which might be considered putting a plaster on the issue- and not addressing the issue of the interaction between the two?

This view is supported by the findings of a recent meta-analysis (Dreison et al. 2018) that found that more effective intervention seemed to be related to education and staff training, which might suggest being aimed at tackling the individual-organisation interaction.

My findings suggest the need to think more about values and the consequences that neoliberal philosophies and 'marketization' have had on core values, culture and objectives of the entire organisation. Thus, my study also highlights the significance of training mental health practitioners, not just in 'compassion' but in *critical thinking*. In other words, training institutions might need to train practitioners to think critically about the socio-political context within which they are working, and help them to think about the impact of neoliberal philosophies on priorities within mental health services. Would this help address this issue?

6.4 Evaluation of Quality Criteria

Quality criteria for assessing GT research are offered by Charmaz (2014), Henwood and Pidgeon (1992) and Glasser and Strauss (1967). However, I excluded Glasser's and Strauss's criteria since they originate from an objectivist paradigm. Charmaz's criteria are not specific to CGT and could be applied to different versions of GT. They also do not consider contextual impact, and the researcher's influence on the research. These are important aspects of CGT. Yet, the quality criteria offered by Henwood and Pidgeon do offer such criteria. As a result, I integrated Charmaz's (2014) criteria with those of Henwood and Pidgeon (1992) to provide a suitable framework for evaluating the quality of the present study. An outline of this framework and illustration of how it was applied to the present study can be found in Appendix AA. Below, I evaluate my quality criteria.

6.4.1 Credibility

A significant amount of time was dedicated to familiarising myself with the topic both at a subject level, as well as pursuing a methodological perspective, which allowed for a meticulous approach to the present research. The choice of participants' characteristics also allowed for a deeper exploration of the phenomenon. Moreover, I included in the appendices documents detailing the construction of my theory and categories; the protocol used for data coding as well as relevant documents to evidence the achievement of theoretical sufficiency, thus increasing content validity (Bowen, 2008; Francis et al., 2010; Fusch & Ness, 2015). This, allows the reader to assess and evaluate the claims I made, enhancing the credibility of my research.

I provided evidence on how my categories are grounded in the data, by using transcripts excerpts, as well as detailing solid links between the categories, the data and the research phenomenon, which is evidenced by the interrelationships among

categories and how they are all subsumed under the core category. Further, I looked for negative cases which enabled me to refine the relevance, properties, and boundaries of developed categories, enhancing the credibility of the study.

6.4.2 Originality

This study was the first to construct a theory of how counselling and clinical psychologists sustain their resilience within the NHS, as well as the first to capture the significant role that values play in sustaining practitioner's resilience in this context. My theory contributes to the question of where the problem is located, and although it has its uses, it ultimately may be a simplistic way of thinking about this phenomenon. My study highlights that is not 'either or' and it helps open up about these complex interactions.

6.4.3. Resonance

The codes, categories and core category, provide deeper insights into the complex process of practitioner-organisation interaction. Moreover, my key findings are in accord and expand existing literature, also resonating with the experience of individuals who experienced the NHS context.

Furthermore, this study incorporates the participant's silent meanings and assumptions. For example, the category I constructed as *locating the difficulty*, largely derives from participants' apparently tacit meaning of their personal relationship to the NHS.

6.4.4 Usefulness

My study provides new insights into the mechanisms of resilience in this context. Furthermore, it expands the existing literature on individual/organisation interaction and the literature on resilience in mental health practitioners in the UK. My findings provide new ways of thinking about resilience, practical

recommendations and avenues for future research. Moreover, I anticipate that my theory may be constructed as applicable to other NHS frontline staff.

6.4.5 Reflexivity

I have considered my impact on this study and vice-versa, through the use of reflexivity, providing accounts of such reflections.

6.4.6 Transferability

I believe it is important to consider other possible applications of the findings. For example, my theory can provide insights for practitioners and employers of other organisations. This would require further research, and I have provided detailed contextual factors so that such further research may be possible.

6.4.7 Documentation

I have attempted to exhaustively document the development of my theory and the whole research process and included in the appendices relevant documents. However, I cannot entirely know the cognitive process that brought to the construction of my theory as I experienced this as mostly tacit and contingent on my own subjective experience of the interviews, my intuitions and interests, which silently guided this process according to what appeared more salient to me (Polyani, 1966). However, despite this limitation on absolute transparency, I have provided as exhaustive as possible account of my development of the theory and its nature.

6.5 Limitations

6.5.1 Methodology Limitations

It is important to acknowledge the inevitability of data being co-constructed by participants and interviewer and shaped by the interview's questions (Charmaz, 2006). Indeed, language not only can direct participants but also shapes their narratives. For example, although a definition of resilience was not given, and the

terminology used was intended to only direct participants towards the area of investigation, some of the descriptions provided by participants seemed to hint at the language used in the interview questions.

Another limitation of the present research might be around participants' self-identification as "resilient" or "not resilient". In fact, even though the emphasis was on participants' subjective interpretation of this construct, it could be argued that identities are fluid, and different identities are constructed and actively used in different contexts and points in time (Howard, 2000). It is therefore possible that participants' identity might have been shaped to fit with the aim of the study. This reflection is based on the observation that in the account of some participants there seems to be an incongruence between the quality of their experience and their identification as resilient. Participants identification as resilient was not necessarily associated with the feeling of managing well within this context.

Further, it might have been helpful to ask for participant's feedback on my analysis. However, due to time constraints and the limited availability of participants, I was not able to pursue this. Nevertheless, I did seek feedback from colleagues and from my supervisory team, which have substantial experience of this environment, who found my findings insightful and resonating with their experience of this context.

6.5.2 Representativeness of the Sample

All participants in the sample identified as female. I was not successful in recruiting male participants. Thus, at present I cannot know how having had such a perspective in the sample might have added to my theory.

6.6 Implications of Findings and Recommendations for the Future

Significant implications have been found at different levels: organisational, training, and counselling psychology. These will be discussed together with practical recommendations.

6.6.1 Implication and Recommendation at Organisational Level

This section reflects responsibilities that the organisation and employers should consider. If this relationship between values and resilience in this context exists, the notion that people coming to work in the NHS may have particular assumptions and expectations of doing a job that fits with their professional values has important implications for recruitment.

One of the questions that arise in my study is if it would be helpful for NHS employers to be more transparent with applicants about what it is going to be like.

Further, it would appear that feeling supported and having autonomy have a significant impact on practitioner's wellbeing. Consequently, creating a supportive space and overseeing practitioners' work, without being too strict on controlling how they do it, might make a significant difference for many people. Furthermore, in the attempt to promote a more open and supportive environment, it might be important to ask employees what they feel they need. Some of the practitioners interviewed, didn't feel heard or reported being afraid of talking about their struggles. This could be addressed by placing anonymous advice-boxes in the service as well as promoting platforms, workshops and support groups where talking about, helpful coping strategies, vulnerabilities and struggles is encouraged. However, it could be argued that the problem in the NHS is precisely how to facilitate this kind of safe environment (Francis, 2013) given that the current socio-economic environment insists on favouring market forces (Power, 1997). However, a more conscious effort

to reflect on practitioners' struggle, may promote a deeper understanding of how to prioritise a culture of compassion, rather than a culture of market economy.

6.6.2 Implications and Recommendations for Training and Profession

Similarly, when people come into training, one of the destinations might be working in the NHS – particularly true for clinical psychologists - and my findings pose the questions of whether there might be ways in which training providers could better prepare practitioners for the challenges they are likely to face in this environment. Probably in counselling and clinical psychology courses there is some reference to this already, but my data suggests that maybe trainings should talk more explicitly about resilience.

One way to do this would be to bridge the gap between training institutions and the NHS on a practical level, probably more relevant for counselling psychology training courses as opposed to clinical psychology, given that they do their training in the NHS. Counselling psychologists gain NHS experience during training but it's not the same, and not only there is a greater distance in terms of clinical experience, but there is also a significant difference in values.

Consequently, my data has important implications for counselling psychologists specifically, as there is a greater potential disparity in how values match between counselling psychologists and the NHS compared to clinical psychologists and the NHS.

6.6.3 Implications for Future Contributions

Following on from what was discussed above, my study not only has implications for counselling psychologists, but also elicits reflections on what counselling psychologists can do about this issue. Despite the fact that clinical

psychologists' values align more with work in the NHS, counselling psychologists could be a great asset in addressing these issues.

For example, counselling psychologists could be more involved within the NHS and help to promote a more reflexive way of working, which may facilitate a reconnection with a culture of compassion.

Finally, if this problem around values in the NHS will be recognised, and there is a concrete will to try and manage the situation better, my study could be the foundation for a new initiative in the NHS. It could be the starting point to create a new role to help implement the practical recommendations suggested in the foregone sections. Something like a "Wellbeing Mentor Scheme", where each practitioner could have a 'Wellbeing Mentor' assigned, specifically trained to provide service-specific resilience training. These could have regular meetings. This would also acknowledge and appreciate the value and hard work of the employees, which links back to my earlier point of creating a more dedicated, supportive space.

6.7 Future Research

As previously mentioned, the lack of male perspectives does not allow for a complete overview of this phenomenon. A replication of this study, one which incorporates perspectives from both male and female practitioners, would further the scope of my theory. Furthermore, investigating other mental health practitioners such as psychotherapists/counsellors might promote insights into different ways in which mental health practitioners may be supported, as well as test the specificity of my theory. This would support organisations and training institutions in their endeavour to support practitioners' wellbeing.

Further, given that my study only focuses on people currently working in the NHS, a future investigation could qualitatively investigate the resilience of

practitioners who left the NHS and conduct an exploratory study of such phenomenon. This could further the scope of the present research.

In light of the direction of my findings as well as the possible issues around participants' self-identification as resilient discussed in the limitations section, it might be interesting to recruit participants without asking them whether or not they identify as resilient. In such a context a discourse analysis approach might provide a useful means of developing an understanding of the way participants construct the meaning of the concept of resilience and how this shapes their experience in this context.

Finally, given the suggestion of the central role that values play in sustaining resilience, a future research avenue could be in conducting a quantitative study measuring resilience and practitioner's perceived alignment with their organisation's values using designated scales. This could provide further insights as to the link suggested by this study between resilience and the alignment of values.

6.8 Concluding Reflexivity Statement

Reflecting on the whole process of research, I recognise the complexity of the concept of resilience and its contextual nature. My personal conceptualisation of resilience changed as a result of this investigation. I moved away from the idea of resilience being a characteristic, to it having a more relational connotation, being negotiated between the individual and their context as well as between the individual and their core values.

Further, the idea that clinical psychologists would find easier sustaining their wellbeing, was challenged and I found myself surprised to acknowledge that even if clinical psychologists in the sample managed generally better than counselling

psychologists, the difference between the two professional titles was not as obvious and clear as I had previously anticipated.

Having only limited previous experience of NHS work, the applicability of my findings to my personal experience might be limited. However, in reflecting more generally about clinical work, the concept of alignment of values resonates with my experience within the organisation where I work. In fact, the way in which I am asked to work mirrors the way in which I conceptualise client work, making the work more enjoyable despite challenges.

Finally, I feel this research helped me to reflect on our responsibilities as practitioners. It is important not to forget that most of the time in our work we are dealing with vulnerable, traumatised people who live in difficult circumstances and have often experienced little kindness and compassion in their lives. These people come to us with the expectation and hope that we will provide help and support; that we will provide a safe space where they will be listened and understood. This is our responsibility towards our clients.

What this research has highlighted for me, is that it's easy to lose sight of this responsibility and to get caught up in unconscious dynamics, both within the organisation and in the work with clients. Moreover, we are constantly trying to fulfil our responsibility towards our colleagues, managers and towards our families, and this might also contribute to pull us further away from the very core values of our profession. Staying true to these values is a constant work in progress.

I don't believe that this awareness and effort to reflect on and talk about the values of our profession will fix things in the complex well-practiced regimen of the NHS. However, I do believe that is our responsibility to put this problem on the map, to elicit discussion and reflection, and increased political awareness of this issue.

I do not feel discouraged in going to work into the NHS, but actually, I see more clearly now how my role of counselling psychologist can contribute to make maybe a small but significant difference, promoting a more holistic approach to the issue, as well as a more reflective way of working within this challenging context.

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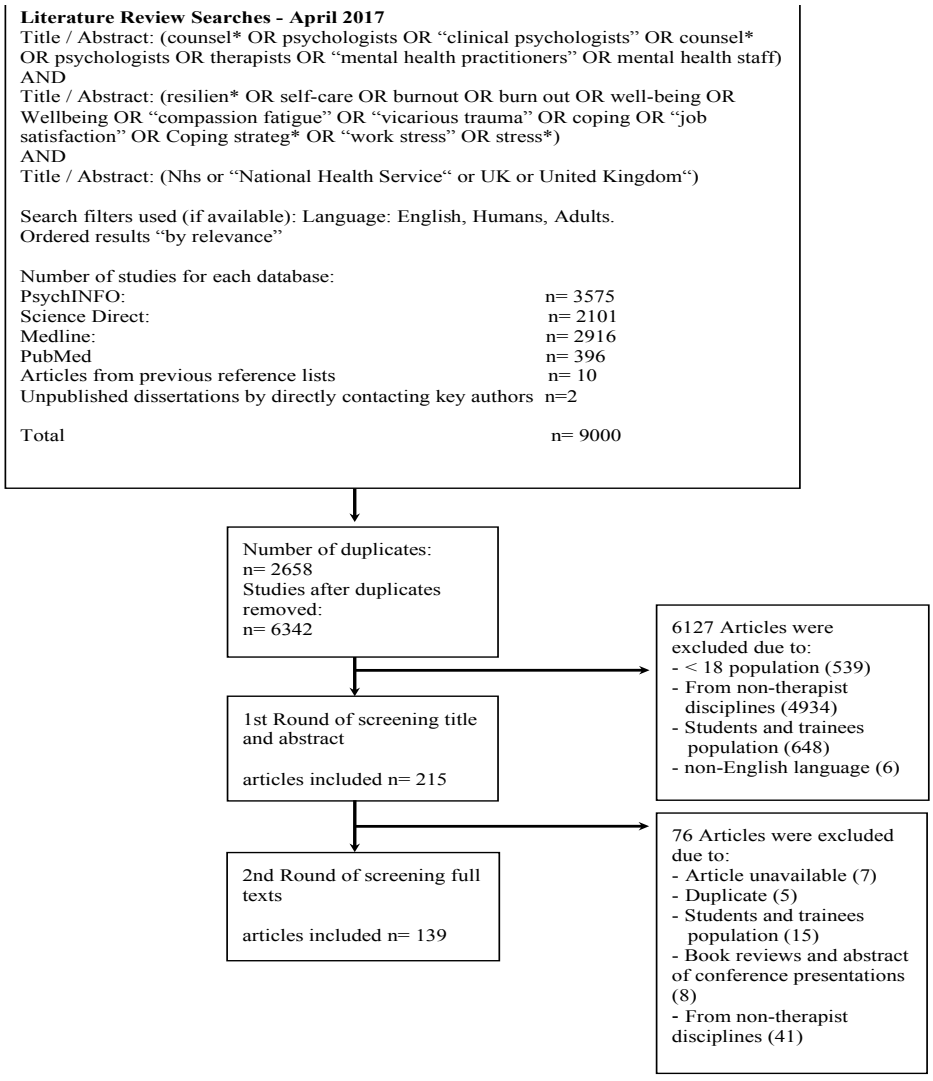
Appendices

Appendix A

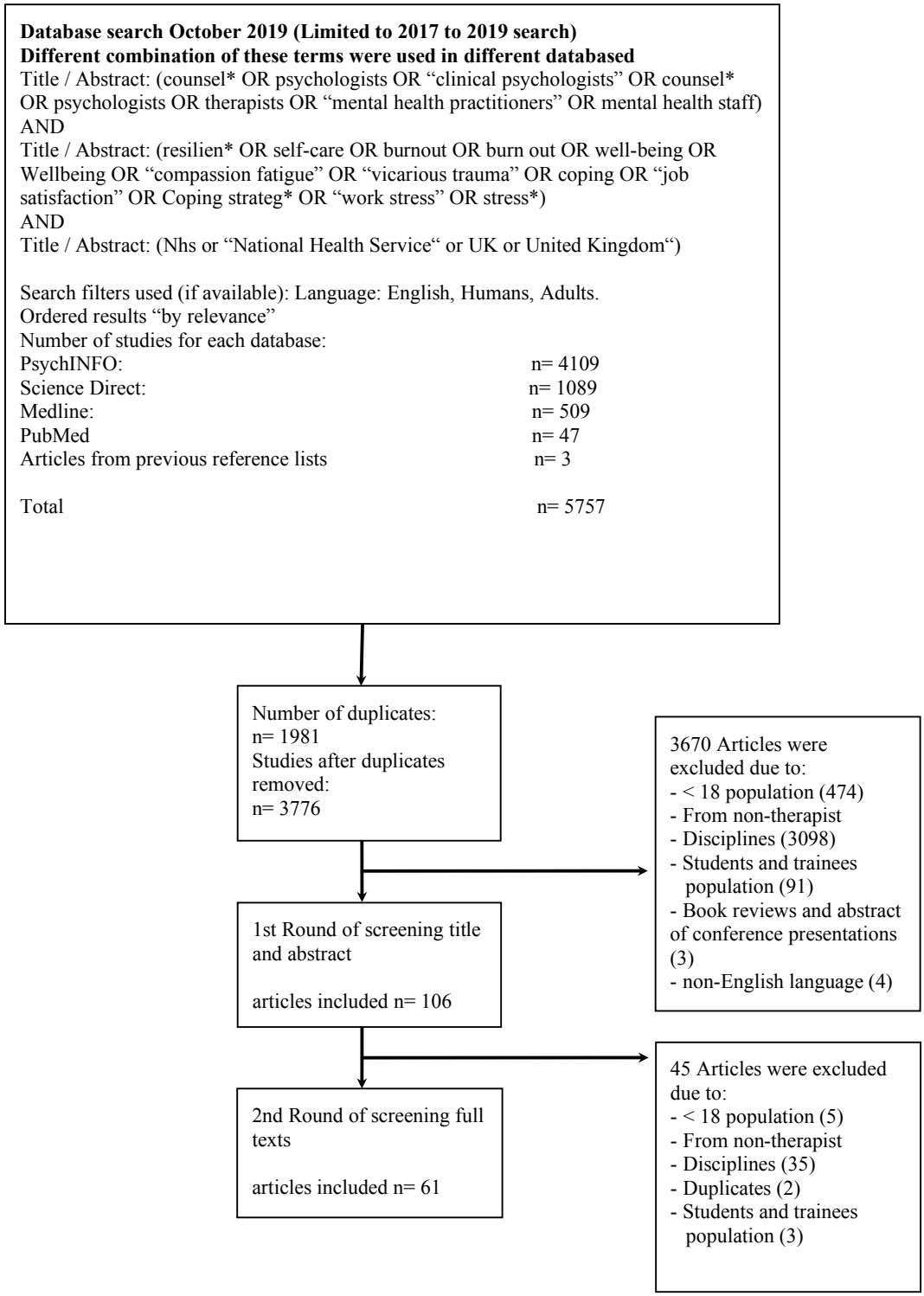
Literature Review Searches

Chosen terms related to resilience were on a continuum with both positive and negative poles, such as wellbeing and burnout as terminology around resilience varies and most studies do not "directly" investigated resilience. Different combinations of keywords were used in different databases to limit the number of false positives.

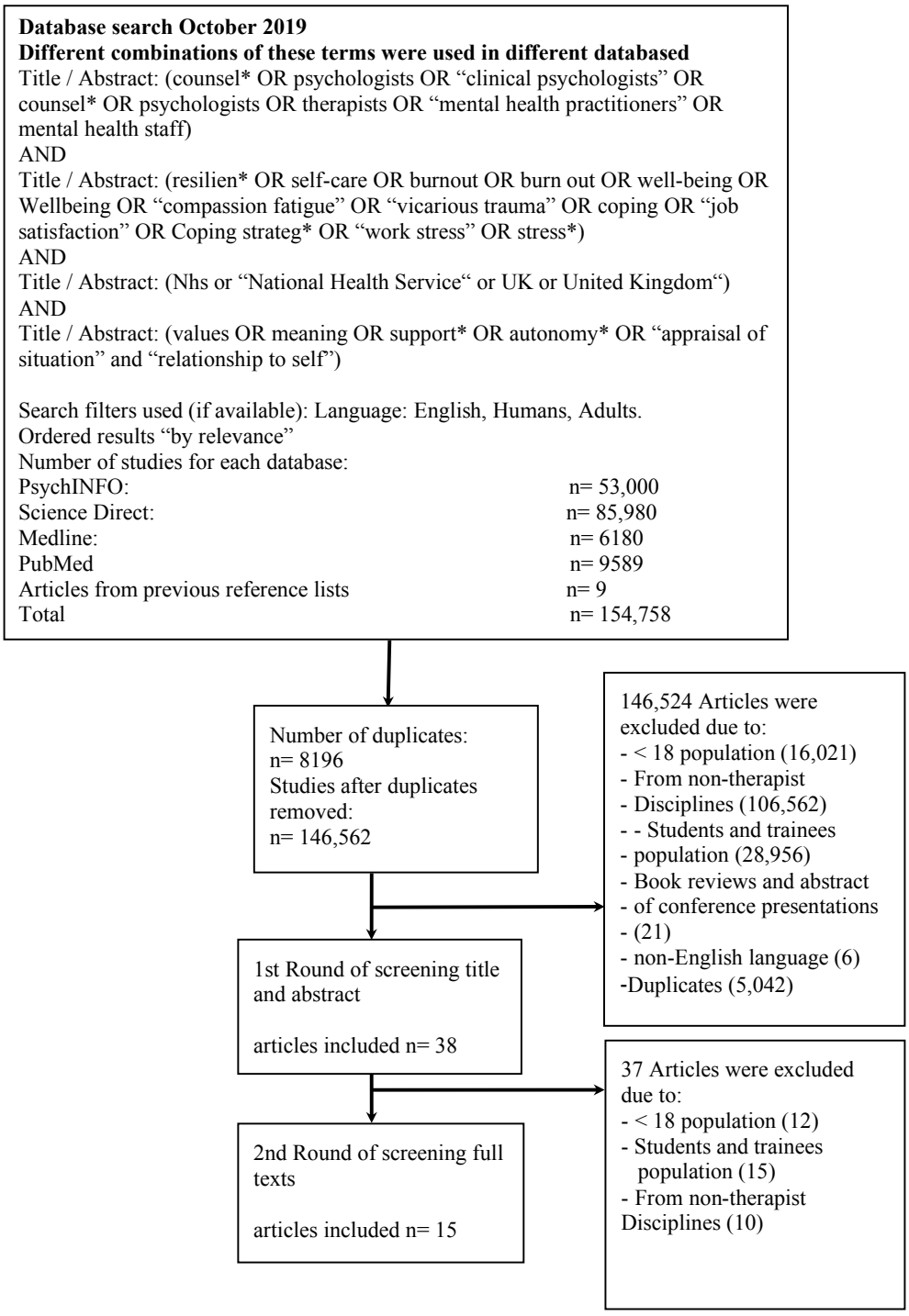
Literature Review searches April 2017:



Literature Review October 2019 (Limited 2017-2019):



Literature Review October 2019 (Adding terminology from analysis):



Appendix B

Interview Schedule for the First Round of Interviews

Note: Some questions or sub questions (*in italics*) may not be asked if already discussed within the flow of the conversation or may not be retained if necessary. This structure allowed for greater flexibility in the discussion and enabled me to be responsive to the individual participant conversation, while not losing track of where I was in the dialogue.

- Prompts used throughout to gain a deeper understanding of their experience depending on the conversation with each individual client:
  - Could you say a little bit more about that?
  - Could you give me an example?
  - It sounds as if…. Is that right?

1 Could you tell me a little but about why you agreed to participate in the study?

2 How would you describe what resilience is? What does being a resilient practitioner mean to you?

3 Do you feel your work (in the NHS) requires you to be resilient? If so, can you say why?

- *Do you feel you work impacts on your well-being? If so, in what way?*
- *What aspect(s) of your work do you find most challenging to your wellbeing and resilience? Can you tell me more about that and why?*

4 How do you think you cope with these challenging aspects of your work?

- *What helps you to stay resilient?*
- *Are there any particular things that you or strategies you use?*
- *Are there particular characteristics you recognise in yourself or others that you consider related to resilience?*

5 Have there being any times when you have felt less resilient? Could you tell me more about that experience?

- *What keeps you working here?*

6 Is there anything else about this subject you would like to say about this subject or that we haven't spoken about yet that you think is important, before we finish?

7 What has it been like talking to me today about your experience and thoughts about resilience?

Appendix C

Interview Schedule for the Second Round of Interviews

Note: Some questions or sub questions (*in italics*) may not be asked if already discussed within the flow of the conversation or may not be retained if necessary.

1- Could you tell me a little bit about why you agreed to participate in the study?

2- How would you describe what resilience is?

3- Could you tell me a bit about your experience of working in the NHS?
   - *Prompts depending on conversation check and clarify concept from initial analysis: Professional values? – support? – control?*
     E.g., Could you tell me a little bit about your experience of support?
     It sounds like you feel that you are working/not working according to how you would want to be working… is that right?

4- What aspect(s) of your work do you find most challenging? Why?
   -Prompts Where you conceived the problem to be? Work? Organisational context? Individual?

5- How do you cope with these challenging aspects?
   - *Prompts: checking and clarifying concepts from my initial analysis*
     E.g., It sounds as if having…. helps you to stay resilient … is that right?

6- Could you tell me about a time when you felt the least able to manage/cope?

7- What keeps you working in the NHS?
   - *Prompts: checking and clarifying concepts from my initial analysis – Values? Meaning? Or something else?*

8- Is there anything else you would like to say about this subject that we haven't spoken about and that you think is important?

9- What has it been like talking to me today about your experiences and thoughts about resilience?

Appendix D

Demographic Questionnaire

Demographics form

Gender: Male [ ] Female [ ] Other [ ]

Age:

Theoretical orientation:

Ethnicity:

Years of Practice since qualified:

Years of Practice in the NHS since qualified:

NHS type of service or services in which you are currently working:

Appendix E

Participant Consent Form

University of Roehampton London

PARTICIPANT CONSENT FORM

Title of Research Project: Resilience in Practitioner Psychologists working in the NHS

Brief Description of Research Project, and What Participation Involves:

I am interested in finding out about your experience of your work, your understanding of resilience, and how you cope with the most challenging aspects of your role in the NHS. I am recruiting between ten and fifteen participants. If you decide to take part in the study, I will ask you to complete this consent form and a short demographic form. The interview will take between approximately 50 and 60 minutes, and will be audio-recorded.

Investigator Contact Details:

Norma Scevoli
Department of Psychology
University of Roehampton
Whitelands College
Holybourne Ave, London
SW15 4JD
scevolin@roehampton.ac.uk
07519298296

Consent Statement:

I agree to take part in this research, and am aware that I am free to withdraw at any point without giving a reason, although if I do so I understand that my data might still be used in a collated form. I understand that the information I provide will be treated in confidence by the investigator and that my identity will be protected in the publication of any findings, and that data will be collected and processed in accordance with the Data Protection Act 1998 and with the University's Data Protection Policy.

Name …….

Signature ……

Date ……

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator or their Director of Studies. However, if you would like to contact an independent party please contact the Research Director below.

Director of Studies Contact Details:

Dr Mark Donati
Department of Psychology
Whitelands College
Holybourne Ave, London
SW15 4JD
mark.donati@roehampton.ac.uk
020 8392 3626

Research Director Contact Details:

Professor Mick Cooper
Department of Psychology
Whitelands College
Holybourne Ave, London
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020 8392 3627

Appendix F

Study Information Sheet

University of Roehampton London

Study Information sheet

Resilience in Practitioner Psychologists working in the NHS

The research Project

This study aims to explore how counselling and clinical psychologists who work in the NHS understand and maintain resilience. I am interested in finding out about your experience of your work and how you look after yourself. Developing more insight into how psychologists cope with the demands of working in today's NHS is especially important given evidence which highlights the increasing demands and stresses on front-line staff working in mental health services.

Developing a better understanding of how psychologists understand resilience and deal with the challenges of working in the NHS may help develop greater awareness of the difficulties they face as well as how they cope and remain resilient. This in turn may lead to a more informed and proactive approach to the provision of staff support in the NHS, as well as professional education and training.

The information below explains what participating in the study would involve. Please read this information carefully and if there are any parts that you would like to know more about, please do not hesitate to contact me. The study has been reviewed and granted clearance by the University of Roehampton's research ethics committee.

Am I eligible to take part in this study?

I am looking for counselling or clinical psychologists who identify themselves as 'resilient'. This means that you generally feel able to sustain your professional effectiveness and personal wellbeing despite the stresses and challenges of your work. This is not about feeling that you have never experienced any difficulties, but that you feel that you are generally managing well with the demands of your working context.

I am also looking for counselling or clinical psychologists who have at least 3 years' post-qualification experience of working in the NHS and are currently still working in the NHS. You do not have to have worked exclusively or on a full-time basis in the NHS to be eligible to take part in the study, provided you have worked as a counselling or clinical psychologist in the NHS for at least 3 years.

Do I have to participate?

No, taking part in the study is completely voluntary. If you do decide to participate in the study, you will be asked to sign a consent form. However, you have the right to withdraw consent from the research at any time, including during the interview and without having to provide an explanation.

What will participation involve?

I am aiming to recruit between ten to fifteen participants. If you agree to participate in the study, you will be asked to take part in a 50-60 minute interview with me, which will be audio-recorded. If you are interested in getting involved, a suitable time and place for the interview will be agreed. The interview could take place either at the University of Roehampton library in a dedicated room, or at another suitable location that is convenient for you. I would be happy for example to travel to your home to conduct the interview. If you would like to take part in the study but it is difficult for some reason to meet in person for an interview, it may be possible to conduct an interview via Skype.

At the time of the interview, you will be asked to complete a consent form and a short demographic form. These would be sent to you in advance of the interview so that you have a chance to read them and ask any questions. In the interview, you will be asked about your work experience, how you feel you cope with the challenging aspects of your work, and your thoughts about staying resilient.

After the interview, you will be also asked if you know anyone else who you think might be suitable to participate in the study. If you do have someone in mind that could potentially meet the inclusion criteria, I will ask if you would be willing to pass on to them the study information sheet and my contact details.

Are there potential risk or disadvantages to participating in the study?

There are no particular risks in taking part in the study. Given that the participating in the interview will involve inviting you to reflect on aspects or experiences of your work that may have been challenging for you, it is possible that this may bring up some discomfort, or strong or distressing feelings. If this occurs, you will be free to not answer any question or to withdraw from the interview altogether at any point without having to give a reason. Some time will be taken at the end of the interview to answer any questions or explore any concerns you may have as a result of your participation.

You will also be provided with a debrief sheet, which provides information on sources of further support if you feel you might benefit from these.

Are there benefits to participating in the study?

Although you will not be financially rewarded for participating in the study, you may find reflecting on your work experience and the role of resilience an interesting or helpful experience. Another potential benefit of participating in the study is the

contribution you will be making to our understanding of an important and relatively neglected area of staff practice and policy in mental health service provision. The findings may reveal more about the particular challenges placed on the practitioner, and about the ways in which practitioners feel they maintain resilience in this context. This could be helpful in developing more awareness of positive aspects of practice and approaches to resilience within the NHS, which might inform the way training programmes address the possible ways in which resilience can be maintained and help to prepare trainees for the challenges they may encounter in this particular work environment. Similarly, the findings of the study could inform NHS managers about the challenges experienced by their staff and what they find useful.

What will happen to the information I provide?

The information that you share will be used for research purposes only. Only the researcher and their project supervisors will have access to participants' data, with the exception of the consent form which contains identifying information and only the lead researcher will have access to this. The audio-recordings of interviews will be transcribed and any potentially identifying details will be removed, such as references to names of people, places or organisations. The interview transcripts will then be analysed, looking for insights and themes that help to develop a more systematic understanding of the topic. Quotations from your interview may be used to support analysis of the data but these would be anonymised so you would not be identifiable. Findings from the research may also be published in academic journals and presented at conferences. The original audio recording of your interview, your signed consent form and demographic information form will be kept separate from your interview transcript in a locked and secure location; the audio-recordings of interviews will be stored on a password-protected computer in an encrypted folder. An identification code will be assigned to you in the event that you wish to withdraw your data from the study. The data collected for the study will be kept for a period of ten years.

Confidentiality

The information that you share will be kept confidential. The data will be kept confidential and stored in accordance with the Data Protection Act (1998) and the procedures to maintain confidentiality have been approved by the University of Roehampton's research ethics committee. Any data from the interviews which is included in presentation or publication of the study's findings will be anonymised. All identifying details, including but not limited to places, names, organisations and addresses will be deleted to ensure anonymity. There may be limits to confidentiality if a research participant discloses information that they or someone else may be at risk of harm. In such situations, the researcher has an ethical obligation to follow safeguarding procedures, and if appropriate disclose information to the relevant authorities. In such cases, this would be discussed where possible with participants before appropriate action is taken.

Contact details

If you are interested in taking part in this study or would like more information about it, please do not hesitate to contact me at the following e-mail address: scevolin@roehampton.ac.uk

Thank you for reading this information sheet.

Norma Scevoli (Lead Researcher)

Appendix G

Participant Eligibility Criteria for the First Round of Data Collection

Round One - Participant Inclusion Criteria

Criteria	Justification
1. Participants must be qualified psychologists, either Counselling or Clinical.	This requirement is considered essential to guarantee standardisation of content in order to permit and facilitate solid comparison of data across interviews. At this stage of the investigation I decided to recruit only Counselling and Clinical psychologists and thus, excluded other professional groups (e.g., counsellors and therapists) as my initial literature review revealed that psychologists may have multiple roles in the NHS compared to other professional groups, which may contribute to burnout. Further, professional groups may vary in terms of self-care, coping strategies and values-based practice (McCann et al. 2013). Thus, I believed that focussing on professionals working in similar roles may give clearer insight into ways in which such employees experience and sustain resilience. For similar reasons, I have decided to recruit only Counselling and Clinical psychologists and not differentiate between these two professional titles. Simultaneously, I excluded all other titles of qualified psychologists as the literature suggested that Counselling and Clinical psychologists account for a large proportion of 'psychologists' working in the NHS and will both be included in this study given that the research evidence on the current situation in the NHS does not differentiate between Counselling and Clinical psychologists, and the limited resilience-related literature on this professional group (Lit. Review). I considered it necessary to investigate both groups to also explore whether there might be

	differences in how they understand and sustain resilience. I decided to apply these sampling criteria in order to minimise difference at this point of the investigation, as I aimed to develop valid conceptual categories (Urquhart, 2013) on the phenomenon of resilience among Counselling and Clinical psychologists working in the NHS. This would make possible for me to answer the present research question and hence generate a grounded theory.
2. Participants must be currently working in the NHS in any type of service in any modality (full-time or part-time) and must be working in the NHS for at least 3 years post-qualification.	This requirement is essential to guarantee that participants have current exposure to the NHS environment as well as sufficient experience of working in the NHS to increase the chance that they may have developed an understanding of resilience and the possible ways in which they feel they maintain it in this context. This requirement also guarantees standardisation of the context that will allow me to contextualise the research within a specific social environment. It is also pivotal to answer my research question and facilitate comparison of data across participants as above; hence, the generation of a grounded theory.
3. Participants must self-identify as 'resilient'- a brief description of what is meant by 'resilient' was provided as follows: "This means that you generally feel able to sustain your professional effectiveness and personal wellbeing despite the stresses and challenges of your work. This is not about feeling that you have never experienced any difficulties, but that you feel that you are generally managing well with the demands of your working context."	This requirement is essential to make sure that participants provided relevant and rich data in conjunction with standardisation of context that would enable me to compare and contrast participants' data, thus answering the research question, and generating a grounded theory of this phenomenon. The requirement of self-identifying as resilient is considered essential given the lack of resilient-related literature in the U.K. (Lit. Review). It is particularly related to practitioner resilience and thus the lack of a unified definition or conceptualisation of this phenomenon within the NHS social context. It promotes exploration of the meaning

	that participants attribute to this concept. This was central to answering my research question.
4. Participants must be willing and able to take part in a face-to-face interview and thus must live/work in London or South England area, so that the researcher can travel to their chosen location - either their home or work place, or alternatively they are able to travel to the University of Roehampton, London.	This requirement was essential so that data could be collected through a face-to-face interview rather than via Skype or other technological means. I believed this would result in higher data quality, as researcher, and participants would have the opportunity to experience each other during the interview. In line with grounded theory, the explicit content of the interview is not the only relevant aspect, but also the researcher-participant relationship and construction of the interview, plus contextual aspects like participants' location choice may reveal more of their unspoken words (Charmaz, 2009). Hence, this approach places a particular emphasis on mutuality and I believed that face-to-face interviews would facilitate this.

Appendix H

Participant Eligibility Criteria for the Second Round of Data Collection- based on Theoretical Sampling Principles.

Note: The following criteria were defined in response to my preliminary theory and were intended to address and possibly fill the gaps and/or leads identified in my developing theory (see 'Justification'). The terminology used in the Justification column to illustrate the gaps in my preliminary theory is derived from the diagram for Round One P1-P9 (Appendix W) and the Theoretical Coding Template P1-P9 (Appendix V).

Round Two - Participant Inclusion Criteria

	Criteria	Justification
1.	Participants must be either Counselling/Clinical psychologists or 'non-psychologists' belonging to other professional groups such as qualified therapists.	At this stage of the investigation, a point of satisfactory theoretical sufficiency (Dey, 1999) is achieved regarding how Counselling and Clinical psychologists understood and sustained their resilience. To clarify, I believe that the data gathered so far from Counselling and Clinical psychologists and the characteristics highlighted in the first round of recruitment (Appendix G) provided a "sufficient depth of understanding" (Dey, 1999, p. 257). The data was sufficiently similar concerning emerging categories, and new insights were not obtained in the last two interviews, despite differences in terms of participants' experiences and demographics. I therefore felt confident in claiming a satisfactory degree of theoretical sufficiency (Dey, 1999). Thus, I decided to recruit at least one member of other professional groups, such as therapists, to look at the phenomenon from a different angle, and to determine the explanatory power of my preliminary theory. By using theoretical sampling to maximise the differences, I intended to define the boundaries of my existing categories (Urquhart, 2013). For instance, interviewing "non-psychologists" would allow me to determine whether

	the emergent theory would only apply to Counselling and Clinical psychologists - and if that was the case, how and to what extent - so as to refine and define the boundaries of the following categories: "Working according to their professional values"; "Values of the role"; "Values of the profession". Moreover, the rationale to interview a therapist emerged from the data itself, as participants referred to seeing 'non-psychologists' members of their team (e.g., therapists, social workers) struggling within this environment. I have seen this as a possible lead to pursue in the attempt to have a wider overview of the resilience phenomenon in the NHS context. At the end of Round One it seemed that what determined practitioner resilience was 'Working according to their professional values' which consequently allowed them to perceive the fulfilment of their professional role, and I considered it useful to theoretically sample 'non-psychologist' professionals to test the properties and boundaries of my preliminary core category. Moreover, still in line with my preliminary theory and aiming to maximise the difference, I decided to interview an additional clinical or counselling psychologist with different characteristics of Round One recruitment as explained in Criterion 3. This would allow me to test my preliminary theory (Urquhart, 2013) and possibly reach sufficient saturation of some of my existing categories.

2. (Same as Criterion 2 of Appendix G)	(Same as Criterion 2 of Appendix G)
3. At the point of the interview participants must report struggling in managing within this environment or having issues with the way in which they were practising within it, not perceiving a supportive environment, and/or thinking of leaving the NHS.	In Round One, I recruited participants who self-identify as resilient and even though there was a significant variety of the range of experiences within this sample, I recognised this gap, as these were all participants who felt they were mostly managing, with the exception of one participant – P7. Consequently, I considered it important to sample participants with a different type of experience to entirely account for all my existing categories. In fact, having developed categories from the first round of interviews, I now needed to focus on a specific type of experience within this context to test my emergent categories via the use of negative case analysis. This is where participants are not feeling they are managing or who report a stronger sense of struggle to stay within this environment. Without interviewing participants who did not feel able to manage within this context, I would not be able to fully answer the research question as I could not test the factors that may contribute to creating difficulties in working within this environment. By sampling participants who had this type of experience would allow me to test the scope/range of the "Perception of the organisational environment" category. Actually, at the end of Round One it seemed that only two out of nine participants interviewed did not perceive the environment as supportive and allowing autonomy within their work; thus, I considered it important to theoretically sample practitioners who did not perceive the environment as such to completely account for this category. Further, via these negative cases the category "Strategies to strengthening internal resources" and "Locating the difficulty" could be fully accounted for by sampling participants who did not

	perceive manging within this context. Likewise, the category "Meaning" seemed to be an important theme at the end of Round One. This was the case in particular when it was linked to the "Fulfilment of professional role" category. Further, recruiting participants with this criterion would help to test the scope/range and characteristics for my preliminary core category "Fulfilment of professional role" as I wanted to test whether this still applied for these participants and if that was the case, to what extent, as this would validate and confirm (or not) the findings from my preliminary theory.
4. (Same as Criterion 4 of Appendix G)	(Same as Criterion 4 of Appendix G)
5. Preferred if participants identified as 'male'	All participants in Round One identified as 'female'. Consequently, I felt it important to recruit participants who identified as 'males' for my theory to have stronger explanatory power regarding the resilience phenomenon within the NHS. Further, my initial Literature Review did not provide insights on the possible differences between genders within this context. It is important to state that this largely depends on recruitment and related limitations, such as time constraints, and it might not have been possible to recruit participants who identified as male, given that I had not been successful in their recruitment to date.

Appendix I

Advertisement of the study published in the August and October 2018 issues of the BPS e-newsletter for the Division of Counselling Psychology

Are you a COUNSELLING or CLINICAL PSYCHOLOGIST who has been working in the NHS for the last five years?

Do you feel that you are generally a resilient practitioner?

If so, I'd be really interested in hearing from you!

Hello,

my name is Norma Scevoli and I am undertaking a study at the University of Roehampton for my doctoral research project looking at how counselling and clinical psychologists understand and maintain resilience in the challenging context of today's NHS.

I am interested in finding out about their experience of their work and how they look after themselves. Developing more insight into how psychologists cope with the demands of working in today's NHS is especially important given evidence which highlights the increasing demands and stresses on front-line staff working in mental health services.

I am looking for counselling and clinical psychologists who have at least 3 years' post-qualification experience of working in the NHS and are currently still working in the NHS on a full-time or part-time basis, to participate in a brief interview to share their views and experiences on this topic. I am also looking for counselling and clinical psychologists who identify themselves as 'resilient'. This means that they generally

feel able to sustain their professional effectiveness and personal wellbeing despite the stresses and challenges of their work.

Participation will involve taking part in a 50-60 minutes interview, which will be audio-recorded. A suitable time and place for the interview will be agreed with the participant. The interview could take place either at the University of Roehampton, or at another suitable location that is convenient for the participant. The lead researcher would be happy for example to travel to their home to conduct the interview.
At the time of the interview, participants will be asked to complete a consent form and a short demographic form. In the interview, they will be asked about their work experience, how they feel they cope with the challenging aspects of their work, and their thoughts about staying resilient.

If you are interested in getting involved or would like any further information about it, please contact me on:
scevolin@roehampton.ac.uk

Appendix J

Online Advertisement posted in the Counselling and Clinical psychology divisions Facebook groups

Are you a COUNSELLING or CLINICAL PSYCHOLOGIST who has been working in the NHS for the last three years?

Do you feel that you are generally a resilient practitioner?

If so, I'd be really interested in hearing from you!

I am undertaking a study at the University of Roehampton for my doctoral research project looking at how counselling and clinical psychologists manage and maintain resilience in the challenging context of today's NHS.

If you are interested in getting involved and you can spare an hour of your time to be interviewed by me at a location of your choosing, please contact me on:

scevolin@roehampton.ac.uk

Further information about the study is provided in the Participant Information Sheet below.

Many thanks,

Norma Scevoli

Trainee Counselling Psychologist, University of Roehampton

Appendix K

E-mail sent to potential participants

Subject: 'Study on resilience in practitioner psychologists working in the NHS'

Dear Psychologist,

I am a trainee on the PsychD Counselling Psychology programme at the University of Roehampton and am conducting my doctoral research on resilience in practitioner psychologists and how they cope with the demands of working in today's NHS.

I am looking for counselling and clinical psychologists who have been working in the NHS for at least three years, and who feel they are generally managing well with the challenges and stresses of their work, to participate in a brief interview with me to share their views and experiences on this topic. I am hoping that the findings of the research will improve our understanding and approach to this increasingly important area.

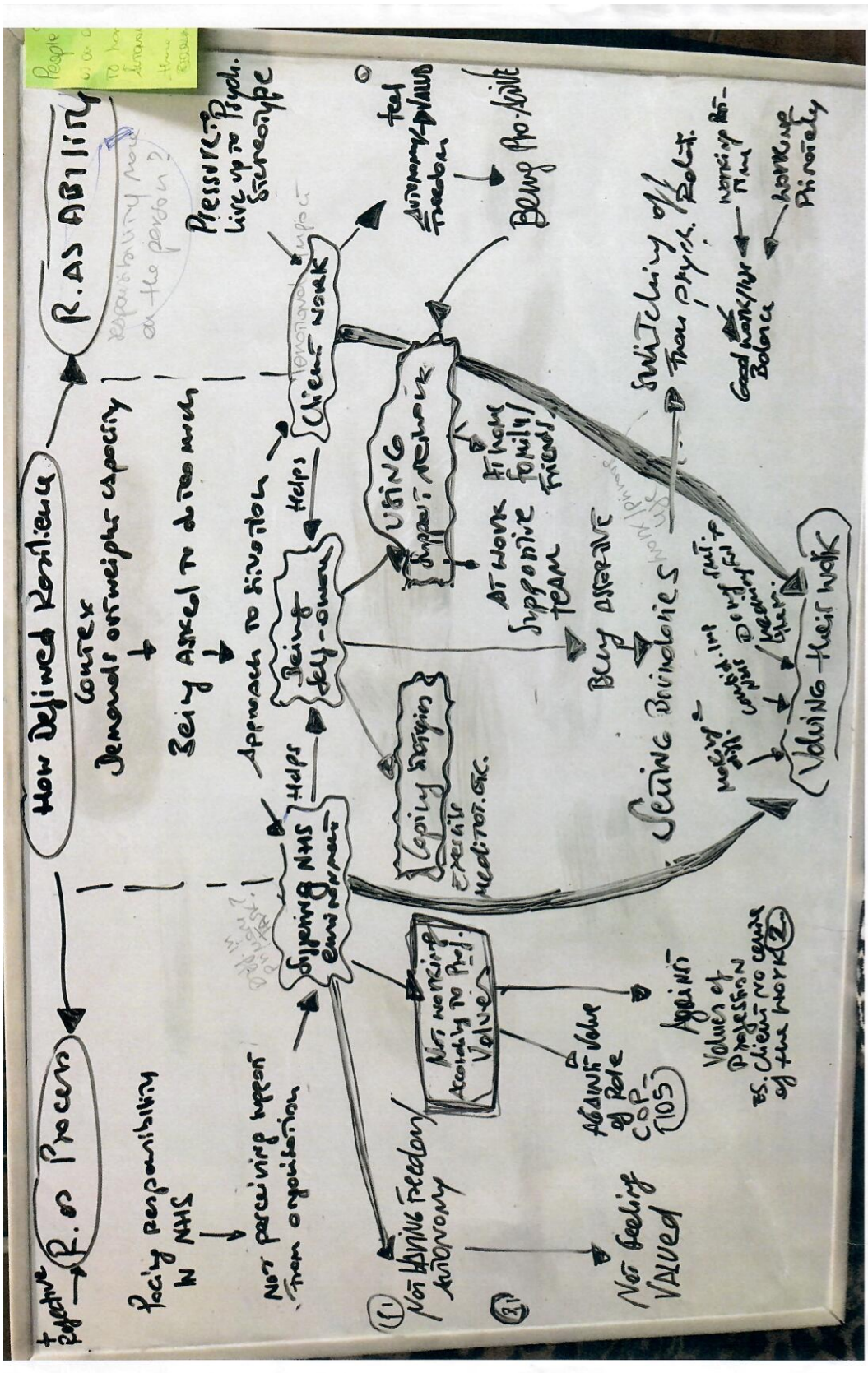
If this is something that may interest you, you can find further information about the purpose of my research study and what participation would involve on the attached information sheet.

If you would like to get involved or simply want to know more about the study, please do not hesitate to contact me.

Thank you for taking the time to read this e-mail.
Kindest regards,
Norma Scevoli
Trainee Counselling Psychologist, University of Roehampton

Appendix L

Initial Overview of the Phenomenon of Resilience in the NHS - P1-P9



Appendix M

Development of Categories for Final Grounded Theory – Evidence of Theoretical Sufficiency

This is an extract from a document that I created in order to illustrate and track the process that led to the development of my core-category, categories, and subcategories to answer my research question. It illustrates what concept was developed for each interview that culminated in the creation of the relative category and consequently my Grounded Theory. This also evidenced the 'point' at which each concept was developed and the consistency of each concept across participants' interviews. Likewise, it represented the similarity of patterns found across participants that in turn suggested the relative category and thus, provided evidence that I had achieved satisfactory theoretical sufficiency. It is best read in conjunction with 'Theoretical Coding Template P1-P9' and 'Theoretical Coding Template P10-P11' (Appendix V) alongside 'Comparison of the Categories of my Initial and Final Grounded Theories' (Appendix X).

Note: concepts were developed through constant comparison and contrast with negative cases.

Legend:
Core category
Categories
Subcategories:
- Primary sub-categories
  - Secondary sub-categories

Concept not present in participant interview: -

Category description	**Participant Interview**	**Concept developed – through memos written after interviews and focused coding procedure**	**Variation or similarities across participants**	**Focused codes that led to developing categories across participants**
Name of category: **6. Fulfilment of professional role**				-Using a model that aligns with principles as counselling psychologists.

Primary and Secondary Sub categories: • Working according to their professional values o Values of the Role o Values of Profession Round One of Interviews and analysis P1-P9	P1	-Need consistency between professional identity and experience/practice and working according to her standard.	P1 reported conflict – struggling because discrepancy between her experience and her professional identity- not fulfilling her professional role in a way she conceived to be appropriate all the time.	-Doing job at their standards. -Overlapping of personal and professional values. -Working under a clinical psychology umbrella. -Not being able to work in a counselling psychology kind of way. -Not working according to professional values of the role. -Not being able to work at their standards because environment hostile and impacts on their well-being. -Misalignment between practitioner and organisation values.
	P2	-Working according to her standards and alignment of professional role and her practice.	P2 felt manging well as felt working according to professional values of role.	
	P3	-Work aligned with personal values	P3 felt able to manage within this context because her personal values were consistent with what she was doing with her work, suggesting alignment of professional values too. Similar to P2 - felt fulfilling her psychologist role.	

	P4	-Conflict of working against professional values of the role.	P4 talked about conflict between her practice and values of counselling psychologist and psychologist. Introduced importance of values of the role, not only profession.	
	P5	-Consistency between her practice and professional role.	Similar to P3- felt fulfilling her psychologist role.	
	P6	-Issues with discrepancies between practice and professional values of the role.	P6 conflict between working as counselling psychologist in an organisation with a clinical ethos - similar to P4.	
	P7	-Work in NHS not fitting the values of profession.	P7 exposed significant discrepancy between professional/personal values and how she is asked to practise - introduced concept of values of organisation. Similar to P1 and to some extent P4.	
	P8	-Discrepancies between way of practising and values of professional role.	Similar to P6.	

Round Two of interviews and analysis P10-P11 Changed name of category: **6. Alignment of Values** *Primary Sub categories:* • Working according to their personal and professional values • Alignment of values between individual and organisation *Properties and boundaries of category:* All participants talked in some form about their values. Some participants referred to personal values, others professional values, others talked about their identity, and others talked about	P9 P10 P11	-Consistency between practice and professional values. -Misalignment of personal values and values of organisation – expanded and better defined and clarified the properties of the previous concept of working in a way that did not feel as fulfilling their professional role and thus in contrast with their personal and professional values. -Discrepancies between inner set of values and the organisation's values, as well as her way of practising in NHS.	P9 Manging very well- similar to P5 and P3 - which is in contrast to experience described by P1, P4 P6, P7, and P8. Similar to P7. Reports in more explicit terms what P7 had said. Exposing strong conflict between personal/professional values and values of organisation. (Re-coding of previous data following the emergence of this concept). Similar to P10 and P7 to some extent. Conflict between set of values and practice/organisation's values and objectives. Also specified and defined previously found relationship between personal/professional values.	

values of the role. Participants talked more or less explicitly about it, and this generated what I call ‘alignment of values’. I have chosen this label because in order to manage within this context, participants seemed to need a kind of consistency between what they were doing, how they were doing it, and what they believed and held true. The term ”alignment” seemed to give the idea of this concept. In my preliminary theory, I called this core category ‘Fulfilment of professional role’; however, that did not make explicit the relationship between the individual’s inner set of values and the organisation’s values, which became evident to me after Round Two of interviews - P10 and P11. The extent to which practitioners were managing within this context seemed to be mediated by the degree to which their set of personal and professional values, aligned with the organisation’s values, and consequently with the way they were practising within this context.				

Name of category: **5. Meaning** *Primary and Secondary Sub categories:* • Making a difference • Doing something meaningful Round One of Interviews and analysis P1-P9	P1	-Valuing the work and NHS– making a difference is pivotal.	For P1, knowing she was making a difference with her work somewhere, was sometimes enough to help her sustain resilience. Valuing NHS institution.	-Finding client work rewarding. - Finding client work meaningful. - Feeling making a difference somewhere. -Not feeling making a difference.
	P2	Finding client work important.	P2 did not explicitly talk about finding the work meaningful. However, a sense throughout interview that working with clients was important for her. But not really struggling so maybe no need to define her 'drive'.	
	P3	-Valuing what she was doing with her day-to-day life, feeling making a difference,	P3 emphasised the fact that she finds meaning because she contributes to making a positive change in people's	

		which makes it meaningful for her.	lives. Finds job rewarding. Similar to P1 – however, less struggle, easier for her to perceive making a difference.	
	P4	-Valuing helping people- meaning of this type of work.	Similar to P1- only feeling making a difference sometimes, somewhere. But enough to be her 'drive'.	
	P5	-Putting the effort for clients - finds job rewarding and meaningful.	Similar to P3 –however, more emphasis on rewarding aspect of client-work, and less emphasis on needing to make a difference, maybe because she perceived making a difference regardless, so did not explicitly address this point?	
	P6	-Finding her job meaningful- valuing what she is doing.	Similar to P1 and P4 but less emphasis on needing to make a difference, more emphasis on enjoying client work.	
	P7	-Valuing her job, but not feeling making any difference.	Slightly different from everyone so far, she talked about the meaning of working in a helping profession doing something 'not just for money'. Also stressing the fact that she	

			is struggling because she is not feeling she is making any difference in people's lives.	
	P8	-Valuing her work /finding rewarding and valuing NHS.	Similar to P1 but less emphasis on needing to make a difference and more emphasis on reward part of working with people that might not be able to afford it otherwise.	
	P9	-Finding helping people meaningful.	Similar to P5.	
Round Two of Interviews and Analysis P10-P11 Changed Name of category: **5. Meaning** *Primary Sub categories:* -Doing something they value - Making a difference *Properties and boundaries of this category:* Almost all participants refer to meaning as their 'drive'. This was the main reason for participants to remain working in	P10	-Finding working in helping profession meaningful-personal value.	Similar to P7, no feeling making any difference.	
	P11	-Finding her work meaningful, enjoys helping people. Making a difference somewhere, sometimes. Personal value.	Similar to P1 and P4.	

such a challenging context. Almost all participants spoke of their work as meaningful and valued by them. However, practitioners sensed their work as meaningful only after feeling they were positively impacting the client's life. Then, they felt they were making a difference. It seemed that it was enough for participants to perceive making a difference, even if only sometimes, not necessarily all the time, to be able to sustain their resilience. If however, they did not feel they were making a difference anywhere, the fact that they valued their job and thought it meaningful was not enough to help them sustain their resilience. Whether practitioners felt they were making a difference, was negotiated within the framework of the practitioner's values.				

Appendix N

E-mail sent to practitioners who expressed an interest in taking part in the study and met the inclusion criteria

Dear Dr….,

I would like to thank you for taking the time to express an interest in this research project about Resilience in Practitioner Psychologists working in the NHS.

In regard to the interview, I am happy to travel to a location that is convenient for you.

Could you please let me know what days you might have available for the interview?

On the day of the interview I will ask you to fill in a consent form and a short demographic form, which I will bring in hard copies for you, so you don't need to print anything out. However, I have attached a copy of the documents so that you have a chance to have a look at them before our meeting and have the opportunity to raise any issues or concerns that you might have in regard to the forms or your participation in the study.

Thank you again for getting in touch and supporting this project.

Looking forward to hearing from you soon,

Kind Regards,
Norma Scevoli

Appendix O

Initial Coding

This is an extract from the initial coding stage of P3's transcript to illustrate coding for 'actions' and how I practically coded the data using alternate colours to delineate the beginning and end of each unit of meaning. For an overview of the complete coding procedure, read this Appendix in conjunction with Focus Coding (Appendix S); Creation of Tentative Categories from Focused Coding for each Participant (Appendix R); Tentative Categories developed via Focused Coding across Participants (Appendix T), and Theoretical Coding Template (Appendix V), so that the development of the 'Setting Boundaries' sub-category, from the first stage to the last stage of coding is trackable. These provide a small overview of how I developed my categories.

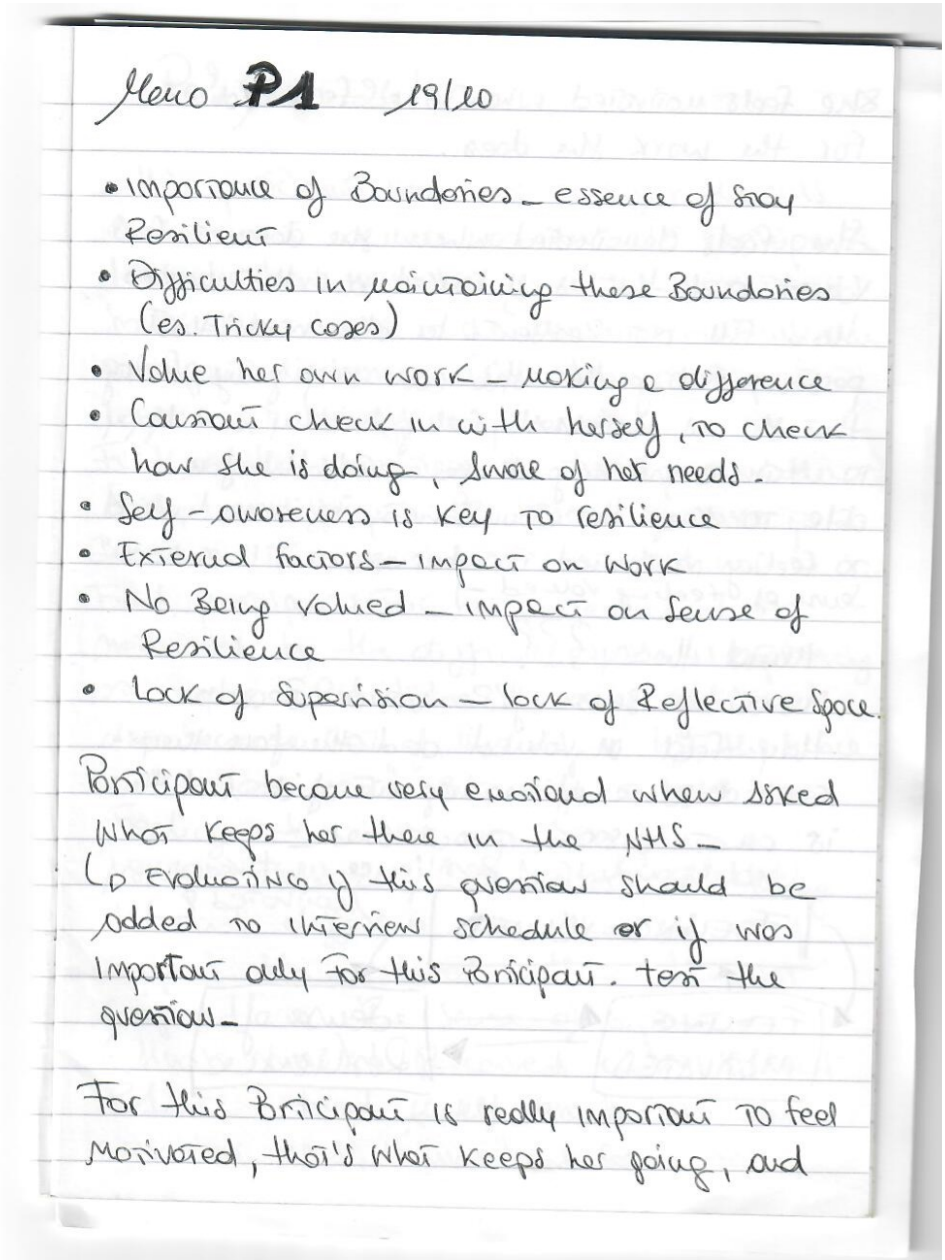
130. I've always	Stating importance of
131. thought of it as being about boundaries, so I	boundaries
always say to	
132. people my work mobile goes off at five	Setting clear boundaries
o'clock and it doesn't	
133. come back on again until nine o'clock the	
next morning. I	
134. never take my laptop home with me to do	
work at home unless	
135. I'm working from home, but I never take it	
home to do work	
136. at the weekends or to do work in the	
evenings, because I need	Highlighting importance of
137. to have those boundaries. I	boundaries
138. need to be able to walk out of this building	Leaving work at work
and leave all of	
139. that stuff here, so leave the work here, leave	
the emotional	Being able to separate from
140. stuff here and be able to kind of separate	emotional staff of work
myself from it. So,	
141. I think being resilient, for me, is about	Linking having boundaries to
having clear	being resilient

142. boundaries. This is my work which I can put myself into and 143. I can put my emotions into, but when I leave here, that's it, 144. I'm now into my personal life and I don't let myself think 145. about my clients and I've blocked that side of work time. And 146. if I notice myself starting to think about, 'yes, this person, I 147. should probably give them a ring', and 'what shall I do with 148. my next session?' I start to kind of catch myself and 149. disengage from it because I think that's not helpful, I think 150. you become overwhelmed by the work if it's constantly on 151. your mind in that way. I do think another thing with resilience 152. is having the opportunities to offload and to talk about the 153. difficult things that we do, and obviously, you've got formal 154. structures like supervision for doing that.	Compartmentalising Noticing when work intrudes Catching and stopping herself Highlighting importance of disengage from work Considering importance to offload Expressing importance of talking about work Seeing supervision as opportunity to offload

Appendix P

Memos written after each interview – Data Collection Stage

This is a sample of the memos written after each participant interview, to illustrate how I used memo writing at this stage.



Memo P1 19/10

- Importance of Boundaries – essence of Stay Resilient
- Difficulties in maintaining these Boundaries (es. Tricky cases)
- Value her own work – making a difference
- Constant check in with herself, to check how she is doing, aware of her needs.
- Self-awareness is key to resilience
- External factors – impact on work
- No Being valued – impact on sense of Resilience
- Lack of supervision – lack of Reflective Space.

Participant became very emotional when asked what keeps her there in the NHS –
(D Evaluating if this question should be added to interview schedule or if was important only for this Participant. test the question –

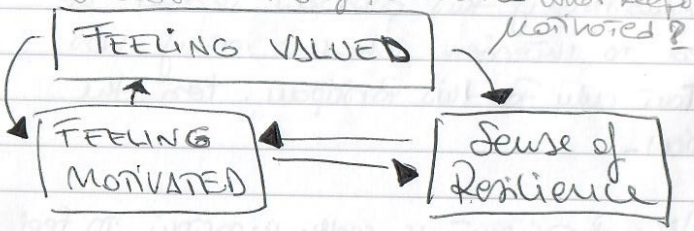
For this Participant is really important to feel motivated, that's what keeps her going, and

She feels motivated when she feels valued for the work she does.

She feels demotivated when she doesn't feel valued and that is all linked and that makes them fill not Resilient - In other words that person feeling that she can keep going, feeling that she is ~~motivated~~, feeling healthy and happy to continue working there and therefore able to keep her boundaries, is very linked to feeling motivated for her which is linked to sense of feeling valued -

Mind theory???

Sustaining sense of Resilience Because they feel ~~M~~ valued and therefore they Get a sense of meaning out of it and this is what sustain practitioner -



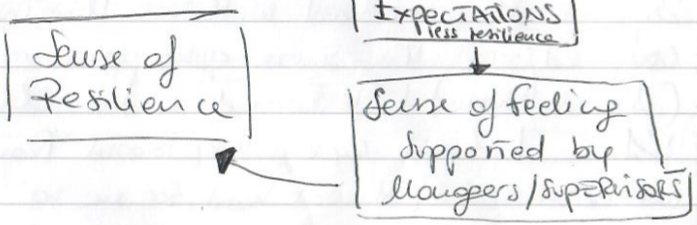
P2 Zoom 24/10

- This participant seem not to suffer the NHS environment as much as the 1st participant - I wonder how much being in the workplace rather than home to do the interview influence participant disclosure - with this participant I went to her office -

Further, the motivation to participate in the study was different - P2 agreed to take part Because she remembers how hard was to find participants for her project and NOT motivated by the difficulties she is experiencing as maybe P1 did - She only add "and also because 60% of Psychologist left the service in the last year" - But didn't have the Feeling that she was struggling as much generally - However, one thing I found difference was the sense of support she received within the NHS compared to the sense of support (almost none) I perceived with Client P1 - I found myself very biased from interview no 1, it was hard for me to

NOT ASSUME things, & had to be ~~not~~ very careful also in not guiding her responses Based on what I found in interview no 1 –
In few Points I think I realised I was using Questions in a way that might have led slightly her responses – I need to be more careful in the next interviews –
Didn't ASK her WHAT keeps you here can SOMEWHAT come up... NOT suffering of ? work

- Use of Physical exercise & meditation
- Weight of expectations on her & time restrains Impact on Sense of Resilience
- Talking & Getting support from her senior & managers/Supervisor always helped her to overcome difficult moments at work ("it's ok if you say no")
- also husband / family support & being listen to
- Recognise & knowing own limits as a way of taking care of oneself –
- Interview Surely helped to think of Implementing Meditation Practice in which Break to help her maintain her resilience –



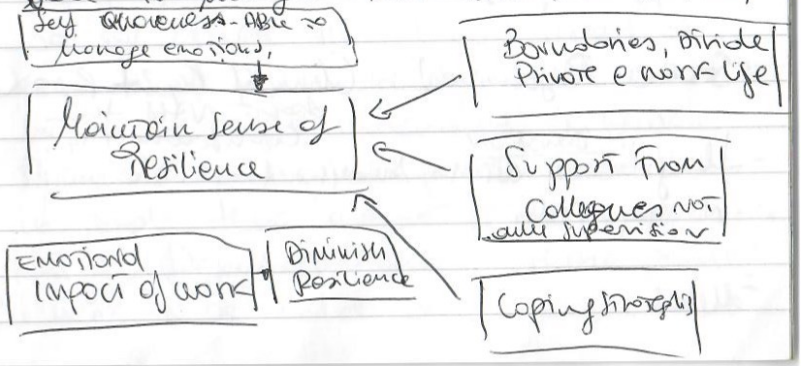
Further this participant gave me permission to contact her again in case I need people who left the NHS as she knows many from her team who left last year because situation was too demanding & it was not a good place to be –

→ outside & inside factors that help.
– Relationship between how understand it & how they maintain it?
–

P3 Memo 2/11/2018

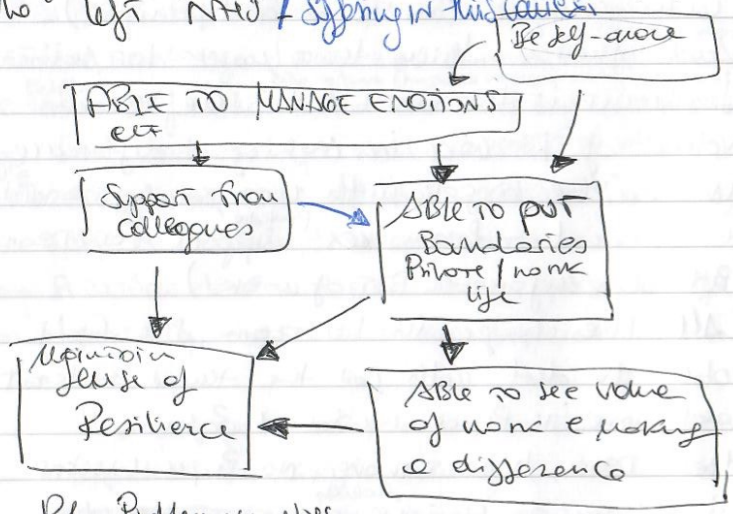
What helps stay resilient is boundaries between personal e work life (leave work at work) + exercise
Be self-aware and able to recognise how you feel and what you need - support from colleagues
what struggle in NHS is with emotional impact of the work e + Demands than resources.
Staff less resilient → cos personal life was particularly difficult e then impacted on work

Even this participant was managing ok with work and felt that her struggles were more related with personal aspects of their emotional life because emotional, very normal to be affected by -
Even this participant was in the work place e not, so have I wonder if this might affect her responses -
- I didn't ask the question of why you stay there because it felt she enjoyed the work more than suffer its because she has learnt to have e keep boundaries between work and Private life, self-aware, of what she needs, able to catch herself when she brings work at home, also uses coping mechanism such as exercise e unloading with colleagues (not only in supervision) -
And another thing that makes her maintain resilience is the fact that she sees the value of her work in making a difference
What she struggle with was mainly, emotional impact of work + Demand - Resources, Provide support for team
(But also enjoyable part of work)
All the changes in her team, she feels able to deal with cos the things she learnt and have in Place mentioned before -
Has team huge turnover, no psychologists
But many are leaving mainly cos their own emotional don't have emotional management skills - e therefore not able to manage their stress and anxiety -



~~Should I interview People~~

- Strong feeling of wanting to interview people who left NHS / suffering in this ~~career~~ Role



P1 Problem in NHS

- Issue in the NHS Social context?
  or People are not good enough or coping?
  P2/3 People's fault.

- Source Defensive? Clinical Psy. + Positive about NHS than Counselling Psy?

- things IN discussion came out in analysis that were not in my Radar

- Memos =

P4 MEMO

Client felt in a hurry. This participant was the first counselling Psychologist I interviewed and we met at her home (NOT NHS ENVIRONMENT). She seemed to push as well on side of too much Demand & too little resources available as well as very MUCH BIG IMPACT of the emotional side of work. She seemed to attribute that problem was placed onto the people by the NHS "seems that People should be able to cope with everything but Actually, we can't expect ~~that~~ so much from ~~people~~ ourselves and our teams. So for her seemed to be that Problem within NHS lies in NHS Social context & not on the people that are "not Good enough". So for People that I interviewed at home saw problem in NHS Social context where as people interviewed at work Place, saw as implied problem ~~that~~ lies in people that are not able to cope with things. Defensive stance of these people? "I'm ok to be interview at work cos I have

Appendix Q

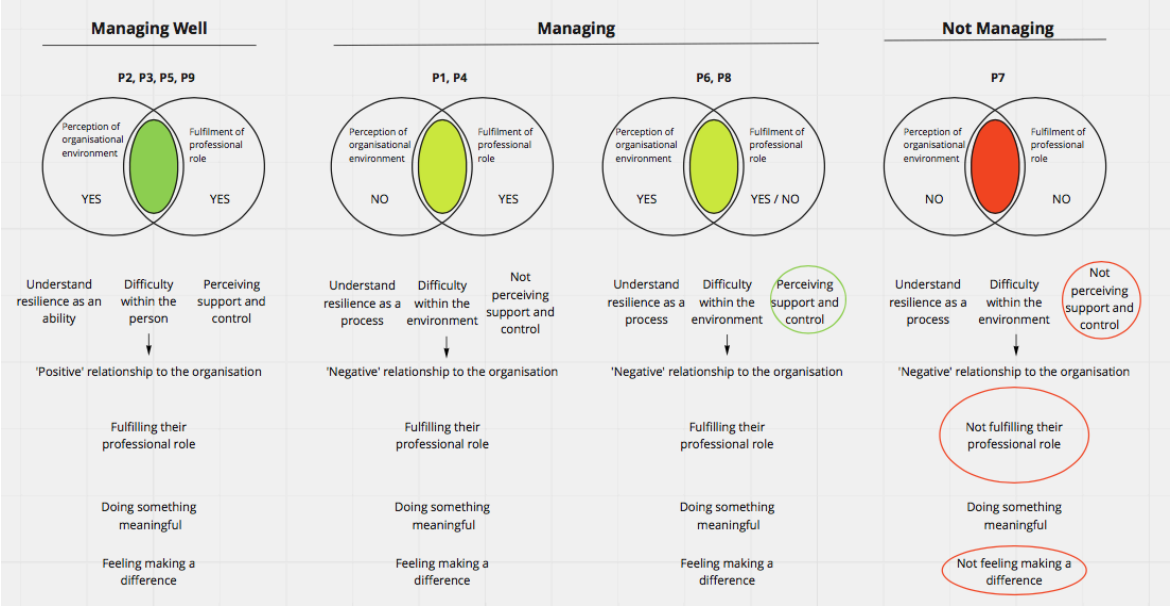
Memos - Analysis Stage

This is an example of the memos I wrote during the analysis stage of P1-P9. I believe this document illustrates my analytic process in the construction of my theory and how I considered my data and participants at this stage of the investigation.

Memo P1-P9. Initial thoughts on possible emerging theory

The construction of my theory is situated in the specific context described by participants, which is one characterised by limited resources and large caseloads. Despite presenting differences in the way in which they feel they are managing within this context, all participants talked extensively about this challenging environment and the difficulties they have in working in today's NHS. I made sense of this by deducing that the struggle/challenge is the site of where resilience is conceptualised and negotiated. Participants associated resilience with the concept of managing and coping in the face of challenging situations.

Because of this association made by participants, as well as data from the memos written after each interview and notes made during the coding process, a pattern started to emerge, and I started to see participants belonging to three separate categories: People who were 'managing well', 'managing' and 'not managing'. Although all participants considered themselves 'resilient practitioners', there were significant differences in the way they felt they were managing. Reflecting on this particularity, I then started to compare the different codes across participants, and make comparisons both across participants and across the three categories developed with the negative cases found within the sample. This was the starting point for the development of my theory through conceptualising and defining the relationships between the participants' experiences and events and possible relationships between these:



My theory constructs how practitioners sustain resilience is related (how? Not sure if is correct to say this yet) to their individual understanding of it, which is negotiated within the practitioner's relationship to the organisation.

Therefore, their conceptualisation of what is resilience was quite 'individual', which I constructed from the data gathered in response to the specific question of "What is resilience?" When they were asked this, participants tended to give an answer, which I perceived as relating either to something that the person was able to do (ability/skill), or it described how they understand resilience by explaining how they were maintaining it. I believed that they saw resilience as a process or some type of interaction with the environment rather than a particular set of characteristics or abilities.

The individual understanding of resilience, whether they conceive resilience to be an ability or a process, seemed to determine where they conceive the strain to be, and whether they locate it within the person or within the environment.

Where they locate the difficulty to sustain resilience gives indications of the quality of the practitioner's relationship to the organisation, which I constructed as being either a 'positive' relationship if they conceive the issue to be within the person and a 'negative' one if they conceive the issue to be within the environment (as blaming the environment).
The concept of the existence of a 'relationship to the organisation' developed quite early in the research process, from memos written after interviews and reflecting on the participant's choice of location for the interview.
In fact, people that chose to be interviewed at their home are the people who struggled more, and are also the people who located the responsibility within the environment. The people who chose to be interviewed at work are the people who place the responsibility within the person and struggle much less in terms of maintaining their resilience in this context. There were two participants that struggled with the environment but chose to be interviewed at work, but that was for purely practical reasons. They initially tried to find a suitable time for us to meet at their homes, but for different reasons, and we could not make that work.

This seems to suggest that the choice of location for the interview says something about the pre-existing relationship between the participant and the organisation - and also provide supporting evidence of the existence of 'a relationship' to the organisation. It would seem that people who did not feel happy (and 'safe'?) within the NHS environment, for different reasons, felt better doing the interview at their home.

(At the same time, the quality of their individual relationship to the NHS influences their conceptualisation of resilience?)

Further, the practitioner's relationship to the organisation is also shaped by their individual perception of the organisational environment, that is, whether they perceive support from their team and the organisation as a whole, and perceive control within

their role and their team, and whether or not they feel they are fulfilling their professional role, namely whether or not they feel they are working according to their professional values and standards.

My construction is that resilience is then sustained as a result of the negotiation between the practitioner's perception of the organisational environment and the fulfilment of the practitioner's professional role, regardless of the type of relationship with the organisation. However, having a positive relationship with the organisation seems to be associated with less struggle. In fact, both the perception of the organisational context and the fulfilment of their professional role contribute to produce a sense of meaning. Finding meaning seems to be mainly dependent on whether the person feels they are fulfilling their professional role, which is facilitated if the person perceives support and control within this environment.

This negotiation seems to be also supported by the use of strategies that are focused to reinforce the individual's internal resources. In fact, these strategies to replenish, reinforce, maintain internal resources, increase the individual perception of support, increasing their ability to ask/get/use support, and perceive a sense of control within their work, which, as already mentioned, contribute to help practitioners to work according to their professional values and standards. Further, where the person conceives the difficulty seems to influence the choice of strategies. These strategies include: the use of active coping strategies, ways of approaching situations, and having a relationship with their own self.
Active coping strategies are the most used. However, these strategies are more used by the people who are 'managing well' than the people who are struggling less in sustaining their resilience.
These active strategies are also used (even if slightly less) by people who are 'managing'; however, are not really used by the participant who is not managing. This suggests that strategies used to strengthen internal resources are important in sustaining resilience, which consequently highlights the importance of the individual's internal resources. The same goes for 'approach to situation'. However, for 'relationship to self' it seems that people who are 'managing' engage more in a reflexive/self-aware approach to their own self than people who are 'managing well', and definitely more than the person who is not managing. Is this because people who 'manage well' don't perceive they have a problem and therefore find less need to engage in such activities? Or is it that they don't have a problem because they don't engage in such reflexive approaches/activities?

Finding meaning in their work, seems to include two secondary subcategories. The first subcategory is whether they feel they are making a difference or feel that they can make a difference in the clients' lives, and the second sub-category is feeling that they are doing something meaningful and that has value for them.

Practitioners seems to feel they make a difference when they feel they fulfil their professional role. I, in fact, constructed making a difference as the result of the fulfilment of their professional role as they fulfil their 'duty' to the clients. Further, whether or not they feel they are making a difference is influenced by the level of support and control they perceive in their organisational environment.
If they don't feel they are working according to their professional values and therefore not feeling that that are making a difference or that they can make a difference (e.g.,

organisation environment doesn't allow it), the meaning for their work diminishes and that's when the person struggles to sustain resilience (see Figure 1).

Further, practitioners seem also to find meaning when they do something that is meaningful to them and has personal value. This level of meaning is also influenced by their perception of the organisational environment, as perceiving support and control produce a sense of feeling of being respected and appreciated/valued for their work, and this also facilitates working according to professional values, which in turn will lead to find a sense of meaning.
If both of these levels of meaning are satisfied then the person is able to manage and cope with the challenges of the context, which I constructed as sustaining their resilience.

Appendix R

Creation of Tentative Categories from Focused Coding and related Memos for each concept, for each Participant

This is an extract from a document I created to list the tentative categories for each participant and relative memo developed as a result of the focused coding procedure before proceeding to the construction of categories 'across' participants (Appendix T). In this Appendix, there is an extract from P3's analysis to illustrate how I practically listed each tentative category with the relative initial codes that composed the category, also including line numbers as revealed in the below example. I also believe this document depicts how I used memo writing during analysis stage to define the properties and boundaries of each concept/category I developed.

Analysis P3

5. Setting boundaries

130 - 131 Stating importance of boundaries
131 – 136 Setting clear boundaries
136 – 137 Highlighting importance of boundaries
137 – 139 Leaving work at work
139 – 140 Being able to separate from emotional staff of work
140 – 142 Linking boundaries to being resilient
142 – 145 Compartmentalising
149 – 151 Highlighting importance of disengage from work

Memo:

P3 talks about the importance of boundaries (same as P1). For her, boundaries have the function of allowing her to leave work at work. These boundaries seem to have the same function they had for P1.

For P2, there was a sense of setting boundaries but this is not included in this category, as for her it was the communication of those boundaries that was the important element. In fact, I included data from P2 in the 'Communication of boundaries' category because it seems that P2 used this as a way of communicating her limits and sticking to them without feeling guilty, which seems to have the function of relieving her from others' expectations in the same way they had for P1. For both, an important aspect about setting boundaries was to be communicated to others, which seems to be the way in which they felt relieved from expectation or pressure to do more, so there is also an element of communicating these boundaries as helping them to maintain resilience because they didn't feel pressured in working long hours outside work times, or didn't feel guilty about setting the limit of what they could do.

For P3, setting boundaries is literally just about compartmentalising, and she does not seem to talk about communicating these boundaries as an important element, unlike

P1 and P2. She seems not to suffer the weight of expectations as much as P1 and P2.

She talks about things like turning off her work phone after 5pm and not bringing her laptop home etc. Boundaries help her compartmentalise and not permit work staff to invade her thoughts or her private life. These boundaries allow her to leave work at work, including the emotional aspects and therefore she separates from it.
She also highlights the importance of disengaging from work.

So, Setting Boundaries → helps her Being able to manage emotions - and therefore able to separate/disengage from difficult emotions within the work or thoughts about work in general → maintain resilience?

6. Having a good support network/Off-loading with colleagues

151 - 152 Considering importance to offload
152 – 153 Expressing importance of talking about work
172 – 176 Having informal channel to offload
176 – 179 Working in a team
179 – 184 Off-loading with colleagues
184 – 187 Feeling the relief of sharing how she feels
187 – 191 Sharing struggles as a way to manage emotions

Memo:

P3 seems to benefit from being able to off-load with colleagues and have someone to listen to her if she is struggling with client work. She talks about the importance of having formal channels to off-load about client work like supervision, but she also talks about needing informal channels, such as talking to colleagues after a challenging session.
While P1 and P2 talked about the importance of having people to off-load with, both mention external people, people in their private life (e.g., husband, mother etc.) while P3 only talks about off-loading with colleagues.
It seems to imply that off-loading with colleagues helps her to leave work at work, so that she doesn't feel the need to talk about her struggles outside working hours.
P3 says that this sharing with colleagues is important in maintaining resilience as it helps her manage her emotions (and therefore not feel overwhelmed), highlighting again the importance of managing emotions and resilience.

Off-load with colleagues → helps her with managing emotions and → compartmentalise?

Appendix S

Focused Coding

This is an extract from the focussed coding stage of P3's transcript to illustrate how I practically coded the data in the transcript using different colours to delineate the beginning and end of each focused code (tentative category). As the same focussed code would appear more times throughout the transcript, I believed it important to create a visual way of seeing its frequency, and have the relevant data clearly defined and delineated, as seen in the below example.

130. I've always 131. thought of it as being about boundaries, so I always say to 132. people my work mobile goes off at five o'clock and it doesn't 133. come back on again until nine o'clock the next morning. I 134. never take my laptop home with me to do work at home unless 135. I'm working from home, but I never take it home to do work 136. at the weekends or to do work in the evenings, because I need 137. to have those boundaries. I 138. need to be able to walk out of this building and leave all of 139. that stuff here, so leave the work here, leave the emotional 140. stuff here and be able to kind of separate myself from it. So, 141. I think being resilient, for me, is about having clear 142. boundaries. This is my work which I can put myself into and	Setting boundaries

143. I can put my emotions into, but when I leave here, that's it,	
144. I'm now into my personal life and I don't let myself think	
145. about my clients and I've blocked that side of work time. And	
146. if I notice myself starting to think about, 'yes, this person, I	Being Self-aware
147. should probably give them a ring', and 'what shall I do with	
148. my next session?' I start to kind of catch myself and	
149. disengage from it because I think that's not helpful, I think	
150. you become overwhelmed by the work if it's constantly on	Setting boundaries
151. your mind in that way. I do think another thing with resilience	Off-loading with colleagues
152. is having the opportunities to offload and to talk about the	
153. difficult things that we do, and obviously, you've got formal	
154. structures like supervision for doing that.	

Appendix T

Tentative Categories developed via Focused Coding Across Participants

This is an extract from a document I developed to list the categories developed through focused coding across all participants' interviews. All the relevant data for each participant that described something that I believed to be related to the relative category is listed here. It is better read in conjunction with Creation of Tentative Categories from Focused Coding (Appendix R).

Setting boundaries

P1:

61-65 "And that whilst there are huge stresses and strains that you're feeling that you're managing that, that it's not, I don't know, whether it's eating away at your self-esteem or that it's coming home with you more than it should."

65-68 "I think it's being able to manage that so that you can compartmentalise it enough that you go, you do what you can"

68-70 "but you can also step back from it and leave as much as possible at work so that it doesn't impact on other areas of life."

73-75 "Hugely. I think that's something that's been really important for me and I think that's the part that allows me to continue"

106-112 "Absolutely. I think psychologists, we … the idea of kind of boundaries if the word that we use quite a lot and we're very familiar with, I think it's something we encourage our colleagues to think about, but for me it's absolutely the most fundamentally important thing in my role is that I have to maintain my boundaries"

121-124 "But I know in order to do that I have to set my limits, I can't just keep saying yes, because otherwise more keeps coming and it would become unmanageable"

126-130 "At times it's tricky but it's certainly something I've learnt to become much better at in my career of being firmer around I can't do that, and that, and that, and that, I can do this, and this, and this."

134-137 "Absolutely. That, A, I can do the work, I can do it to a standard that, you know, that I'm happy with and that is professional, and it means psychologically I'm in a good place"

137-139 "you know, there's peaks and troughs, so sometimes when the workload goes up and then it might settle a little bit more afterwards."

145-148 "I think like I was talking about earlier, about trying to do that difficult job of leaving work at work and separating that and home life, at times that's easier than other times."

445-458 "I think the other key thing, I mentioned before, is about that we need to have real, clear boundaries, of knowing them and being able to set them and stick to them."

461-467 "you know, little things like my NHS email, I'm only two days and I'm two consecutive days so at the end of my second day I put my out of office on that says, please note, I only work two days a week so I'm not available now, I will only be able to respond to this on my next working day which is next week."

467-468 "Others in my position don't do that and at times I think too firm there"

471-475 "So I do do that. And, actually, for me it works, it allows me to … it's part of

my bit of a ritual of, okay, that helps me to close down from that, it helps me to know that I'm putting that down for this week and I can pick it up next time"

P3:

130-131 "I've always thought of it as being about boundaries"
131-136 "so I always say to people my work mobile goes off at five o'clock and it doesn't come back on again until nine o'clock the next morning. I never take my laptop home with me to do work at home unless I'm working from home, but I never take it home to do work at the weekends or to do work in the evenings"
136-137 "because I need to have those boundaries"
137-139 "I need to be able to walk out of this building and leave all of that stuff here, so leave the work here"
139-140 "leave the emotional stuff here and be able to kind of separate myself from it."
140-142 "So, I think being resilient, for me, is about having clear boundaries"
142-145 "This is my work which I can put myself into and I can put my emotions into, but when I leave here, that's it, I'm now into my personal life and I don't let myself think about my clients and I've blocked that side of work time."
149-151 "I think you become overwhelmed by the work if it's constantly on your mind in that way."

P4:

61-64 "other things around resilience are around being able to wrap up and go home at the end of the day and not let things spill into your life."
339-346 "I don't open my emails outside of work, I think that's really important because it would upset my chain of thinking outside of work, and I've got small children so it's important not to do that."
486-489 "but I think, 'you know what, that's how I can do the best that I can'"

P5:

202-209 "It could and I guess there's the point, being xxxx, that then you don't let it impact too much so that you are able to leave things at work and not to take them home."
252-257 "Emotionally, it doesn't impact too much, I think I'm quite able to leave things aside and not to take the emotions with me."

P6:

401-408 "Yes, I suppose 'boundaries' is a good way of looking at it. It is putting boundaries in-place and I suppose that is very connected to resilience, being clear in my own mind what I was prepared to do and not prepared to do."
489-491 "and having boundaries and clear and non-negotiable about what was good for me."
609-610 "So it is learning to say no"
634-636 "I think you have to take a risk and I think you need to be firm."
640-643 "People burn out because they feel they have no choice then to meet the deadlines" assertiveness??

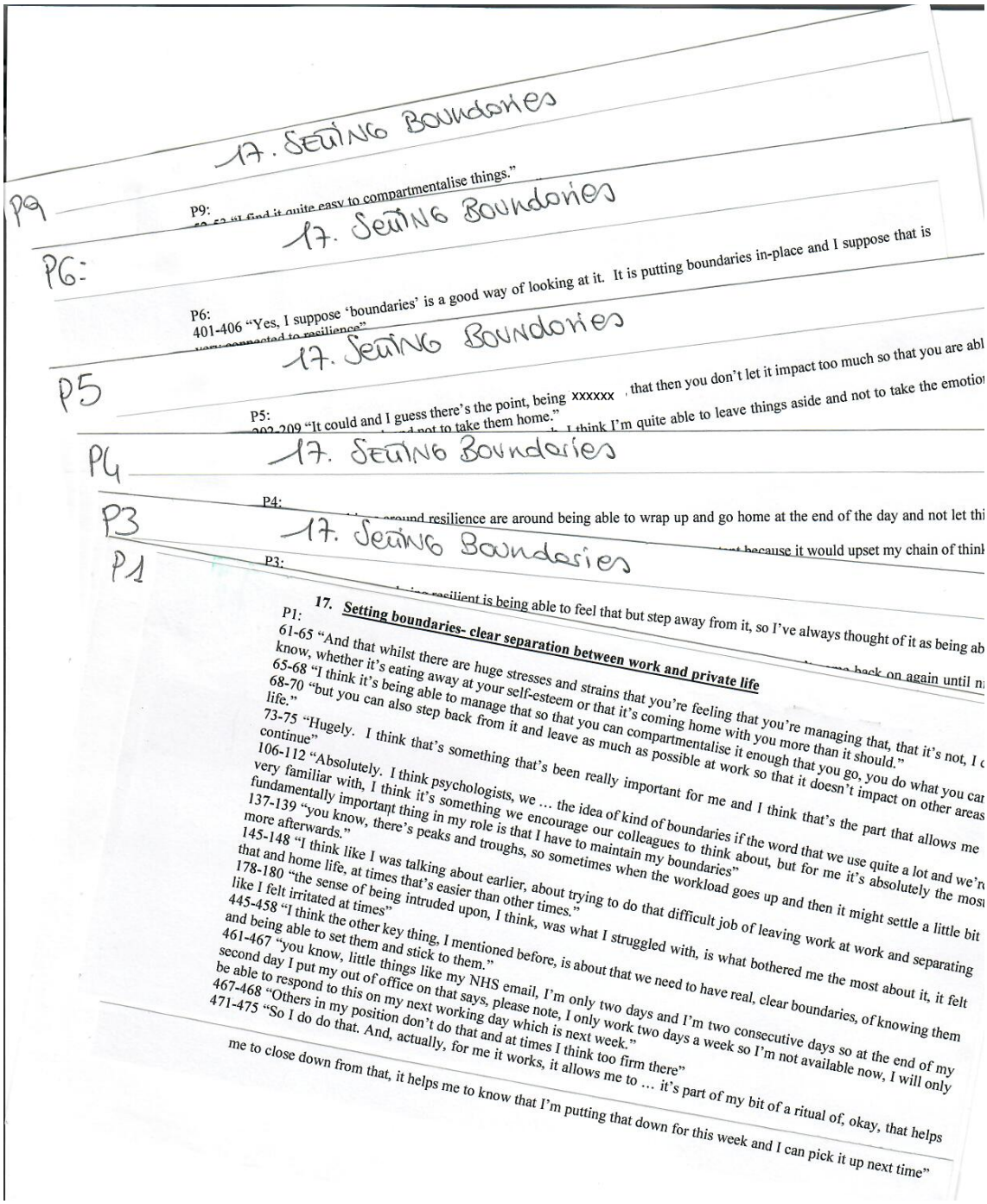
726-727 “You need to have good, healthy boundaries”

P9:
52-53 “I find it quite easy to compartmentalise things.”
53-54 “So I don’t take, I don’t worry about work at home.”
53-57 “So if I have to, I do have to work at home to keep on top of things and sometimes I do have to work in the evenings, but I find it quite easy to switch between work and home life”
57-58 “so I don’t find that I’m ruminating about it or carrying it over into my home life.”
66-68 “So I think that helps quite a lot, I really do find it easy to just switch it off, even when I was working in tier 3”
71-75 “I worked in tier 3 CAMHS for about 14 years and so even when I was managing really high risk clients, when the service was under a lot of strain, I was seeing far too many people, carrying much too much risk, I still actually didn’t worry about them when I went home”
76-77 “because there’s a bit of me that just thinks, “There’s no point worrying about stuff you can’t control.”

Appendix U

Flashcards developed for each Category after Focused Coding

Here is a sample of the cards developed for the 'Setting boundaries' sub-category. Each card included the number of the participant (e.g., P1); the number of the category (e.g., 17); the name of the category (e.g., Setting boundaries); a brief description next to the name, and all the instances of data from the participant's transcript with the related line number.



Appendix V

Theoretical Coding Template

Theoretical coding Template - Development of concepts/categories – subsuming different focused codes – After interviews with P1-P9
Legend:

Core category

1. **Category**
   - **Primary sub-category**
     - *Secondary sub-category*
       - Tertiary sub-category

1. **Individual understanding**
   - **Ability**
   - Describing resilience as an ability/skill
   - Moving on quickly from things

   - **Process**
   - Describing Resilience as a process
   - Describing resilience as an interaction of more factors

2. **Locating the difficulty**
   - **Within the environment**
     - Suffering institutional NHS environment
     - Finding client work the least difficult part of the job
     - Placing the responsibility to the NHS
     - Leaving NHS in order to stay resilient
     - Feeling taken for granted by the NHS
     - Not feeling valued
     - Feeling NHS is placing responsibility in the workers
     - Feeling the pressure of expectations on clinical contacts
   - **Within the person**
     - Being able to manage own emotions
     - Being able to manage external stressful situations
     - Having good emotional management skills
     - Being able to use support and tools available to manage stressors

3. **Perception of the organisational environment**
   - **Perceived support**
     - *Team*
       - Talking to colleagues
       - Having support from manager
       - Having people around who support your work
       - Knowing of receiving support if asked for it

       NEGATIVE CASES- Not perceiving support-
       - Suffering difficult team dynamics

- Having dual relationships with colleagues
- Worry of being seeing less by colleagues- not feeling support from colleagues
- Suffering staff turnover
- Not opening up /seeking support from colleagues

- *Organisation*
  - Having a "staff first" model of management

NEGATIVE CASES- Not perceiving support-

- Not having Support structures within organisation / → Having support structures within organisation
- Not receiving technical support

➢ **Perceived control**

- *Within their role*
  - Having freedom and autonomy within their role
  - Having Flexibility

NEGATIVE CASES

- Not having freedom and autonomy within their role

- *Within their team*
  - Finding solution as a team

4. <u>Strategies to strengthening internal resources</u>

➢ **Active coping strategies**

- *Practical strategies*
  - Doing physical exercise
  - Taking regular breaks
  - Self-care
  - Being Pro-active
  - Being organised and efficient
  - Assigning different priorities
  - Avoiding conflict
  - Setting Boundaries
  - Switching of completely from all psychology related things
  - Being assertive
  - Maintaining a good work-life balance
  - Having a good support network
  - Using humour
  - Using creative Problem solving

NEGATIVE CASES-

- Not opening up with friends / not sharing her feelings with friends

- *Psychological strategies*
  - Practicing Mindfulness

- Meditating
- Stay in the here-and-now

- **Approach to situation**
  - Being realistic
  - Accepting not being able to do it all
  - Maintaining a sense of calm

- **Having a relationship to self**
  - Being self-aware
  - Being compassionate toward self
  - Being reflective/reflexive

5. **<u>Fulfilment of professional role</u>**

- **Working according to their professional values**
  - *Values of the role*
    - Using a model that aligns with principles as counselling psychologists

NEGATIVE CASES

- Working under a clinical psychology umbrella
- Not being able to work in a counselling psychology kind of way

  - *Values of profession*
    - Doing job at their standards

NEGATIVE CASES

- Not working according to professional values of the role

6. **<u>Meaning</u>**

- **Making a difference**
  - Making a difference

NEGATIVE CASES

- Not making a difference

- **Doing something meaningful**
  - Finding client work rewording
  - Finding client work meaningful
  - Doing something they value

Theoretical Coding Template P10-P11

Theoretical coding Template - Development of concepts/categories – subsuming different focus codes – After interviews with P10 and P10

Legend:

Core category

1. Category

- **Primary sub-category**
  - *Secondary sub-category*
    - Tertiary sub-category

1. Individual understanding

- **Resilience as an ability**
  - Describing resilience as an ability/skill
  - Moving on quickly from things

- **Resilience as a Process**
  - Describing Resilience as a process
  - Describing resilience as an interaction of more factors

2. Locating the difficulty

- **Within the environment**
  - Suffering institutional NHS environment
  - Finding client work the least difficult part of the job
  - Placing the responsibility to the NHS
  - Leaving NHS in order to stay resilient
  - Feeling taken for granted by the NHS
  - Not feeling valued
  - Feeling NHS is placing responsibility in the workers
  - Feeling the pressure of expectations on clinical contacts
- **Within the person**
  - Being able to manage own emotions
  - Being able to manage external stressful situations
  - Having good emotional management skills
  - Being able to use support and tools available to manage stressors

3. Perception of the organisational environment

- **Perceived support**
  - *Team*
    - Talking to colleagues
    - Having support from manager
    - Having people around who support your work
    - Knowing of receiving support if asked for it

    NEGATIVE CASES- Not perceiving support-
    - Suffering difficult team dynamics
    - Having dual relationships with colleagues
    - Worry of being seeing less by colleagues- not feeling support from colleagues

- Suffering staff turnover
- Not opening up /seeking support from colleagues

- *Organisation*
  - Having a "staff first" model of management

  NEGATIVE CASES- Not perceiving support-
  - Not having Support structures within organisation / → Having support structures within organisation
  - Not receiving technical support

➢ **Perceived control**

- *Within their role*
  - Having freedom and autonomy within their role
  - Having Flexibility

NEGATIVE CASES
  - Not having freedom and autonomy within their role
- *Within their team*
  - Finding solution as a team

4. <u>Strategies to strengthening internal resources</u>

➢ **Active coping strategies**
- *Practical strategies*
  - Doing physical exercise
  - Taking regular breaks
  - Self-care
  - Being Pro-active
  - Being organised and efficient
  - Assigning different priorities
  - Avoiding conflict
  - Setting Boundaries
  - Switching of completely from all psychology related things
  - Being assertive
  - Maintaining a good work-life balance
  - Having a good support network
  - Using humour
  - Using creative Problem solving

  NEGATIVE CASES-
  - Not opening up with friends / not sharing her feelings with friends
- *Psychological strategies*
  - Practicing Mindfulness
  - Meditating
  - Stay in the here-and-now

➢ **Attitude to situation**
  - Being realistic
  - Accepting not being able to do it all
  - Maintaining a sense of calm

➢ **Attitude to self**

- Being self-aware
- Being compassionate toward self
- Being reflective/reflexive

5. **<u>Meaning</u>**

➢ **Doing something of personal value**
- Finding client work rewording
- Finding client work meaningful

➢ **Making a difference**
- Feeling making a difference somewhere

NEGATIVE CASES
- Not feeling making a difference

6. **<u>Alignment of values</u>**

➢ **Working according to their personal and professional values**
- Using a model that aligns with principles as counselling psychologists
- Doing job at their standards
- Overlapping of personal and professional values

NEGATIVE CASES
- Working under a clinical psychology umbrella
- Not being able to work in a counselling psychology kind of way
- Not working according to professional values of the role
- Not being able to work at their standards because environment hostile and Impact on their well-being

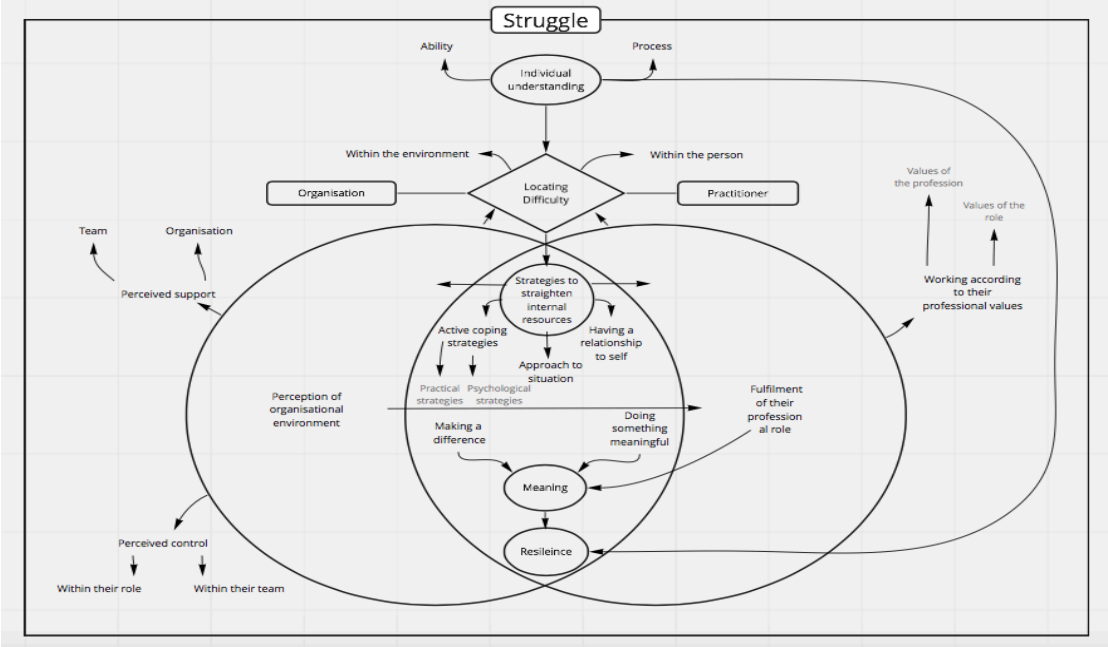
➢ **Alignment of values between the individual and the organisation**

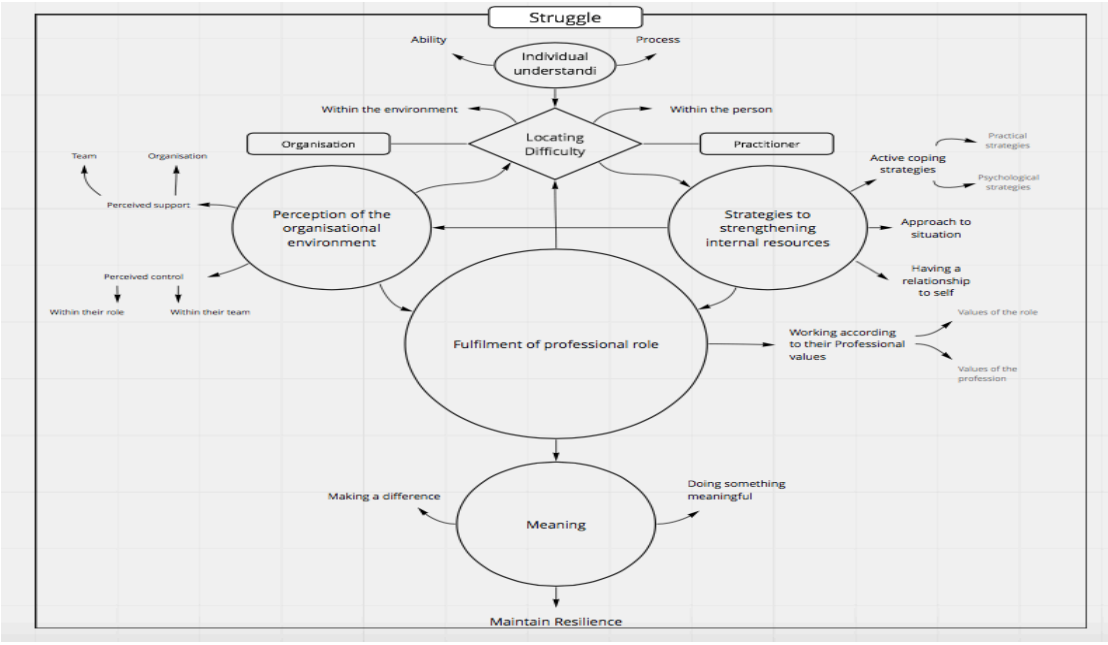
NEGATIVE CASES
- Misalignment between practitioner and organisation values

Appendix W

Preliminary Grounded Theory

This is a visual representation of my preliminary Grounded Theory, developed after interviews P1-P9. It is better read in conjunction with Theoretical Coding Template P1-P9 (Appendix V). The first diagram did not include a preliminary core category, which is defined and represented in the second diagram (Fulfilment of Professional Role).





Appendix X

A Comparison of the Categories of my Initial and Final GTs

Here, I illustrate my initial and final theories, explaining and justifying the changes made to my first theory as a result of the findings from Round Two of interviews that led to the development of my final Grounded theory. This gives a representation of my final theory as it was, before receiving feedback on my first draft of the Analysis Chapter from my supervisory team.
What follows is best read in conjunction with Theoretical Coding Template P1-P9 and Theoretical Coding Template P10-P11 (Appendix V); the diagram of my preliminary GT (Appendix W), and the diagram of my final GT.

Legend
Core category
Categories
Primary sub-categories
Secondary sub-categories
Tertiary sub-category
Categories that remained the same from Initial to Final: -
Categories deleted from Initial to Final: /
Categories that were not present in the initial theory but emerged in the final theory: *

Name of category/sub-category **Initial Grounded Theory**	**Name of category/sub-category** **Final Grounded Theory**	**Description of change and justification – from Preliminary to Final GT**
Individual understanding	-	-
Ability	Resilience as an Ability	I changed the names only for the purpose of clarity and flow in the writing. The concept remained unaltered between the two theories.
Process	Resilience as a Process	Same as above.
Locating the difficulty	-	-
Within the environment	-	-
Within the person	-	-
Perception of the organisational environment	-	-
Perceived support	-	-
Team	-	-

Organisation	-	-
Perceived control	-	-
Within their role	-	-
Within their team	-	-
Strategies to strengthen internal resources	-	-
Active coping strategies	-	-
Practical strategies	-	-
Psychological strategies	-	-
Approach to situation	Attitude to situation	The concept behind these two categories is the same in both theories. I changed the name of the category slightly as I feel that the later version would better express the property of the category. In fact, the words 'approach' and 'attitude' are similar, as both refer to the position of the individual in relation to a situation or to something/someone; however, the word 'attitude' refers to the way individuals carry themselves or place themselves in a particular position/orientation according to their internal set of feelings, beliefs, and behavioural tendencies (Hogg & Vaughan, 2005). It transmits a sense of an innate 'behaviour' that at the same time could require consideration. 'Approach' (Approach, n.d.) refers to the act and the way of advancing near something, a particular way of taking steps towards something, and thus there is more of a sense of conscious intent and less of an innate nature.

		I conceptualised the concept identified in my theory as not something necessarily involving a conscious intent, but rather it seemed to be 'behaviours' that do not require rationalisation, but are quite natural to the person. Therefore, the word 'attitude' gives more of the idea of the concept identified here.
Having a relationship to self	Attitude to self	Similar to the above category.
Fulfilment of professional role	Alignment of values	In both theories, preliminary and final, I identified the concept of values as an important one. In my preliminary theory, I expressed this with 'Fulfilment of professional role' referring to the extent that the individual felt when working according to their professional values, which in my preliminary theory was related to the subcategories: 'Working according to their professional values'; the 'Values of the role' –e.g., counselling psychologists vs clinical - and 'Values of the profession' –e.g. psychologists, being in a helping profession. However, returning to the data following the coding of the second round of interviews, I recognised that 'Fulfilment of professional role' did not account for the full range of experiences described by participants and did not emphasise the concept of values. In fact, re-coding existent data revealed a three-part relationship of values between the individual, the profession, and the organisation. So, I decided to raise the concept of 'values' by also placing the emphasis on the alignment of these values to sustain resilience using the concept 'Alignment of values' in my core category, and subsume the concept of 'Fulfilment of professional role'. The latter only referred to the 'alignment' between the way in which they were practising and the values of the profession/role, but did not include the values of the organisation or emphasised the personal values of the individual.

Working according to their Professional values	Working according to their personal and professional values	In both my theories, final and preliminary, there is a strong emphasis on the importance of the practitioner working according to their professional values to cope with the different challenges of this context, and consequently sustaining their resilience. However, as seen above, in my preliminary grounded theory, the emphasis was placed on the professional set of values of the individual – which in my preliminary theory was described by 'Values of the role' and 'Values of the profession' (see below sub categories). My final grounded theory also identified the pivotal role of the practitioner's personal values, in a manner that my initial theory did not. In fact, the final theory captures the pivotal role that these play in defining the relationship between the practitioner and the organisation, which seemed to determine the extent to which the practitioner is able to manage within this context.
Values of the role	/	In my preliminary grounded theory, 'Values of the role' was listed as a secondary subcategory of 'Working according to their professional values' and I recognised that one factor that seemed to help sustain practitioner resilience was when they were working according to the professional values of the role - e.g., counselling psychologist role. Although this remained an important theme in my final theory and I referenced it, I did not feel this qualified as a category, as only the three counselling psychologists in the sample referenced this, and two of these mentioned it as a result of my direct questioning. Thus, I did not feel it was a significant or adequately recurrent theme to qualify for a sub category.
Values of the profession	/	I did not keep this sub category even though this was a significant theme in seven out of eleven participants'

		interviews. I felt this was already included and addressed in the 'edited' new version of 'Working according to their personal and professional values' category (see above) and did not need a sub category on its own.
*	Alignment of values between the individual and the organisation	In my initial theory, I did not identify a category 'Alignment of values between the individual and the organisation', probably because, as indicated, this relationship between the individual's personal and professional values and the organisation's values emerged/became apparent to me only after re-coding the data following the second round of interviews. I feel this sub category contributes to saturating my core category as it helps explain the full range of experiences described by participants.
Meaning	-	-
Doing something meaningful	Doing something of personal value	Both theories captured the importance for the practitioner of doing something meaningful; however, I decided to change the name of this category slightly, as when returning to the data I felt that the nature of the work is meaningful in itself , but I wanted to emphasise that it was meaningful for them. This is because I am interested in the meaning that they would attribute to the work, regardless of whether it is meaningful or not for others. I found that using the concept 'Doing something of personal value' would emphasise that their job has personal value for them, a factor that is highly significant in them being able to sustain their resilience within this context.
Making a difference	-	

Appendix Y

Debrief form

University of Roehampton London

Debrief form

Thank you for taking part in the study today.

The purpose of this study

This study aims to explore how counselling and clinical psychologists who work in the NHS understand and maintain resilience.

This study seeks to develop a better understanding of psychologists' experience of their work, their understanding of resilience and how they deal with stresses and challenges of this particular working context. This may help to develop more awareness on the difficulties that NHS psychologists experience and the things that they may find useful in managing the challenges of working in this particular context.

In case of distress

In the event that you experienced any distress after the interview, you can find contact details from whom you can seek support.

Your GP

British Association Counselling Psychotherapy: https://www.bacp.co.uk

UK Council for Psychotherapy https://www.psychotherapy.org.uk

British Psychological Association https://www.bps.org.uk

Health and care Professions Council http://www.hcpc-uk.org

Employee Assistance Programme: 0161 836 9020

Occupational Health Department: OccupationalHealth.Enquiries@uhb.nhs.uk

Investigator Contact Details: Norma Scevoli
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Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator (or if the researcher is a student you can also contact the Director of Studies.) However, if you would like to contact an independent party please contact the Research Director.

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Appendix Z

University of Roehampton Centre for Research in Social and psychological Transformation (CREST) Data Protection Policy

Centre for Research in Social and psychological Transformation (CREST)
Department of Psychology

Data Storage and Protection Procedures

Sources

These procedures are informed by, and consistent with, the following sources:

- Roehampton *University Data Protection Policy*, University of Roehampton, May 2010 (revised).
- *Ethical Guidelines for Researching Counselling and Psychotherapy*, British Association of Counselling and Psychotherapy, 2004.
- *Encrypting Confidential Data using Windows XP*, Counselling and Psychotherapy Research Guidelines, Counselling Unit, University of Strathclyde (available via Google Group).
- *Ethical Principles for Conducting Research with Human Participants*, British Psychological Society (accessed Sept. 2008).
- Personal communications with Ralph Weedon, Data Protection Officer, University of Strathclyde

Responsibilities

- The Chief Investigator has overall responsibility to ensure that the appropriate data storage and protection guidelines are followed.

Non-anonymised/personal data

- Non-anonymised (or 'personal') data refers to any form of documentation or media – electronic or otherwise – in which an individual is identifiable. This includes, but is not limited to:
    - signed consent forms
    - client identity forms (including DOB, GP details, gender etc)
    - video recordings

  Note: even if no name or other obvious data is involved that would identify an individual, data such as date of birth, student matriculation number, national insurance number can be 'triangulated', perhaps with other data a third party has acquired, in such a way as to effectively identify someone. Anything that

can be used in this way is therefore to be considered personal data.

- Collection of non-anonymised data will be kept to a minimum, and will only be obtained where it is ethically necessary (as in the case of signed consent forms), or where it clearly adds to the scientific value of a project (for instance, the video recording of counselling sessions).
- Non-anonymised data will be kept for ten years.
- All non-anonymised data will be clearly labelled with a date at which it should be destroyed.
- Non-anonymised data will be destroyed in a way which ensures that the data cannot be recovered in any way.
- Non-anonymised data will be kept physically and/or electronically separate from related anonymised data so that links can not be made between the two sets of data.
- Non-electronic personal data, such as tape recordings and signed consent forms, should be kept in a locked and secure location at all times, and, wherever possible, at the University of Roehampton.
- Electronic personal data will be encrypted and should always be kept on a password protected storage device: wherever possible a PC or network drive located at the University of Roehampton.
- Personal data should not be kept on – or transferred to – laptops, USB sticks, CDs or other mobile/portable devices unless absolutely necessary. As soon as such data is transferred to a secure University location, it must be removed from the portable device such that it cannot be recovered in any way.
- *Should it be necessary to transfer personal data from person to person, this should be done in a secure manner (i.e., by hand or by recorded delivery), always separate from any anonymised data. Any posted materials should be marked 'private and confidential' and sent recorded delivery.*
- For the duration of a study, non-anonymised data may, if absolutely necessary, be stored (in the manner identified above) by investigators other than the Chief Investigator (for instance, where a student is analysing video tapes of counselling sessions). However, on completion of the write-up of the research, all non-anonymised data will be returned to the Chief Investigator for storage, and any copies destroyed.

Anonymised data

- Anonymised data refers to any form of documentation or media – electronic or otherwise – in which an individual is in no way identifiable. This includes, but is not limited to:
    - SPSS spreadsheets in which identifying characteristics (such as age) are not recorded
    - completed questionnaires: qualitative or quantitative
- Anonymised data may be kept for an unlimited period, and may be used for subsequent research projects and data analyses at the discretion of the Chief Investigator (provided that this is made explicit to participants in consent forms).
- Non-electronic anonymised data will be kept in a locked and secure location at all times, ideally at the University of Roehampton.
- Electronic anonymised data may be stored electronically. This should always be to the highest possible standard of confidentiality: for instance, storage in an encrypted folder. It may also be kept on a password protected storage

device, ideally at the University of Roehampton and, wherever possible, will be encrypted. Transfer and storage on portable/mobile devices (such as USB pens) should be kept to a minimum.

- Transfer of anonymised data should be conducted to the highest standards of confidentiality, always separate from any non-anonymised data. Any posted materials should be marked 'private and confidential.' If anonymised data is transferred via email, it should be transferred by the receiver to an encrypted portion of a hard disk as soon as possible, and both sender and receiver should hard delete the email/attachments from their email server.
- For the duration of a study, anonymised data may be stored (in the manner identified above) by investigators other than the Chief Investigator. However, on completion of the write-up of the research, all anonymised data will be returned to the Chief Investigator for storage, and any copies destroyed.

Partially anonymised data (also known as Pseudo-anonymised data)

- This section refers to any form of documentation or media – electronic or otherwise – in which it is highly unlikely that research participants can be identified, but in which the possibility of triangulation exists. This may include, but is not limited to:
    - audio recordings

  Note, if such media includes clearly identifying content (for instance, an interviewee reveals their name or that of their husband on an audio recording), then it will be treated as non-anonymised data until those identifying characteristics are removed.
- Wherever possible, partially anonymised (and non-anonymised) data should be scrutinised and all identifying details should be deleted/erased (for instance, identifying features on transcripts, such as names of partners, should be deleted or blacked out).
- Where all identifying details of partially anonymised data have been deleted/erased, this data will be treated as anonymised data, and subjected to the same procedures as above.
- In instances where partially anonymised data can not be fully anonymised (for instance, audio recordings in which the participant may be identifiable from their voice), this data will be kept for ten years, and will be stored according to the protocols for non-anonymised data.
- Within this ten year period, partially anonymised data may be used for subsequent research projects and data analyses at the discretion of the Chief Investigator (provided that this is made explicit to participants in consent forms).

The eight general principles of the data protection act, 1998

- Personal data shall be processed fairly and lawfully (with specific requirements regarding sensitive personal data).
- Personal data shall be obtained only for one or more specified and lawful purposes, and shall not be further processed in any manner incompatible with that purpose or those purposes.
- Personal data shall be adequate, relevant and not excessive in relation to the purpose or purposes for which they are processed.
- Personal data shall be accurate and, where necessary, kept up to date.
- Personal data processed for any purpose or purposes shall not be kept for

longer than is necessary for that purpose or those purposes.

- Personal data shall be processed in accordance with the rights of data subjects.
- Appropriate technical and organisational measures shall be taken against unauthorised or unlawful processing of personal data and against loss or destruction of, or damage to, personal data.

Personal data shall not be transferred to a country or territory outside the European Economic Area, unless that country or territory ensures an adequate level of protection for the rights and freedoms of data subjects in relation to the processing of personal data.

Appendix AA

Quality Criteria

Quality criteria used to evaluate the quality of my research content and process.
Note: * quality criteria overlap with one another.

Criteria	Relation to present research and brief description of how obtained and/or evaluated	References
<u>Credibility</u> 1. Familiarity with the topic/setting. 2. Sufficiency of data – number, range, depth. 3. Systematic comparison: Observation and categories. 4. Robust logical links between data, analysis and argument. 5. Provide sufficient evidence to allow the reader to develop an independent assessment and agree with what suggested from findings.	1.The research attained a intimate familiarity with the topic/setting - Review of the literature undertaken, all participants worked in the NHS setting and all were interviewed about the resilience phenomenon. 2. Sufficient data was collected to merit claims. Analysis accounts for and clarify negative cases. Achieved satisfatory theoretical sufficiency (Appendix M). 3. Categories emerged from participants data, categories subsumed data from interviews. Constant comparison and memo writing methods used throughout (Appendix O, Appendix P, Appendix Q). Use of theoretical sampling and negative case analysis (Appendix G). 4. Robust links are made between data, analysis, and argument - The development of categories is tracked throughout and the generated categories and their relationships are illustrated and explained (Appendix M, Appendix	Charmaz (2014, pp. 337-338). Henwood and Pidgeon (1992, pp. 105-108): -* "Keeping close to data: importance of fit" 1.Categories fit well the data. -* "Theory Integration" 1. Final theory is meaningfully related to the problem area.

	Q, Appendix S and Appendix W). 5. There is enough evidence for the research's claim to allow the reader to judge their credibility. Consultation with supervisory team was used to evaluate this criteria.	
<u>Originality</u> 1. Categories are fresh and offer new insights. 2. The analysis yield a new conceptual interpretation of the data. 3. The final theory has Theoretical and social significance. 4. The final theory challenges, refines or extends present concepts, ideas, and practices.	1.The analsysis and categories offer new insights – analysis became increasingly more analytical and abstract as it progressed which led to the development of new insights. 2. The analysis provides a new conceptual interpretation of the data – from concrete to abstract, also including silent meanings and assumptions. 3. Theory has both theoretical and social significance as evidenced thoughtout. 4. The final theory challenges, refines/extends present concepts, ideas and practices – consistent with the literature on the importance of values. It contributed to expanding established theories on tensions between the individual and the organisation. Tested via theoretical sampling.	Charmaz (2014, pp. 337-338) Henwood and Pidgeon (1992, pp. 105-108): -* "Theoretical sampling & negative case analysis" 1.Explore negative cases and different experiences in order to modify and/or extend initial theory.
<u>Resonance</u> 1. The categories depict the fullness of the phenomenon under investigation.	1.The categories developed fully depict the studied phenomenon (Appendix W) achieved satisfactory theoretical sufficiency via theoretical	Charmaz (2014, pp. 337-338). Henwood and Pidgeon (1992, pp. 105-108):

2. Revealed liminal and taken-for-granted meanings. 3. Established links between individuals lives and larger collectivities or institutions when revealed in the data. 4. The final theory make sense and provides deeper insights for participants and individuals who share the same context/experience.	sampling and tested through use of negative case analysis (Appendix M). 2. The analysis includes assumptions, silent/ambiguous meanings - revealed and tested via negative cases and memo writing. 3. Established links between the experience described by participants and larger collectivities or institutions when indicated by the data – Links made with existing literature on the field, expanding existing theories. 4. The final theory makes sense to other people that share similar contexts/experiences, providing deeper insights and understanding about their worlds. Evaluated through consultation with colleagues and supervisory team.	-*Theoretical Sampling & negative case analysis. -* "Theory Integration"
<u>Usefulness</u> 1. Analysis provides interpretations that individuals can apply to their everyday world. 2. The categories suggest generic processes. 3. The generic processes have been inspected for silent implications. 4. The analysis can lead to further research in other significant areas. 5. The work contributes to	1.The findings may be used by individuals that experience the context/phenomenon studied in their everyday world - given the credibility and resonance of the findings. 2. The final theory suggests a generic process. 3. The generic processes identified were inspected for silent implications – this was done via negative case analysis, theroretical sampling and comparing memos with data and other memos at different	Charmaz (2014, pp. 337-338).

	knowledge as well as making a better world.	stages, which consequently led to modifying and extending the theory (Appendix W). 4. The research suggests areas for further research. 5. The work contributes to knowledge and makes a beneficial contribution to society.	
	<u>Reflexivity</u> 1. Acknowledgment of researcher's role.	1. The researcher's part is acknowledged throughout the study. This is done by having reflexivity sections, by keeping a reflexive journal, and writing memos including the researcher's thoughts, feelings, and impressions regarding the research process and content.	Henwood and Pidgeon (1992, pp. 105-108).
	<u>Transferability</u> 1. The findings may be applied to similar contexts that differ from the context in which the data was collected. The contextual caracteristics of research are detailed.	The contextual characteristics of the research are included and the impact that these may have had on the data was considered. The findings can be applied to other similar contexts –the generated theory, explains a generic process, which may be provide insights into other similar circumstances (e.g., people who work in organisations in general and not only NHS)	Henwood and Pidgeon (1992, pp. 105-108).
	<u>Documentation</u> 1. Offer a comprehensive report of what is done and the reasons behind it, throughout the investigation,	An exhaustive account of what was done and the reasons behind it, from the beginning to the end of the investigation, is provided.	Henwood and Pidgeon (1992, pp. 105-108).

	documenting both content and process, tracking the analytical process and data generation from initial impressions to final theory.		

Appendix AB

Strategies to support resilience

The table below illustrate strategies to support resilience described and used by each participant.

Practical strategies	Managing Well				Managing					Not Managing	
	P2	P3	P5	P9	P1	P4	P6	P8	P11	P7	P10
Doing physical exercise	X	X						X		X	
Taking regular breaks		X				X					
Self-care	X X	X					X				
Being Pro-active	X X							X			
Being organised and efficient		X	X					X			
Assigning different priorities	X		X			X					
Avoiding conflict	X										
Setting Boundaries	X	X	X		X	X	X				
Switching of completely from all psychology related things				X	X	X		X		X	X
Being assertive	X	X		X	X	X	X	X			
Maintaining a good work-life balance				X	X	X	X	X			
Having a good support network	X		X	X	X		X	X			X

Using humour		X X	X
Using creative Problem solving	X X		
Psychological strategies			
Practicing Mindfulness		X X	X
Meditating	X		X
Stay in the here-and-now	X X		

Attitude to situation	Managing Well				Managing					Not Managing	
	P2	P3	P5	P9	P1	P4	P6	P8	P11	P7	P10
Being realistic			X			X			X		
Accepting not being able to do it all	X X		X		X		X				
Maintaining a sense of calm	X	X			X	X					

Attitude to self	Managing Well				Managing					Not Managing	
	P2	P3	P5	P9	P1	P4	P6	P8	P11	P7	P10
Being Self-aware	X X	X			X	X	X	X		X	X
Being aware of what they need		X			X		X	X	X		X
Being aware of their limits	X		X				X	X	X		

Being compassionate towards self	X X X	X X	X
Reflecting on their experience		X X X	
Being interested in reflecting about resilience		X X X	
Having personal therapy		X	X
Valuing the space to thing and reflect in supervision	X	X X X	